COLORADO

Department of Health Care Policy & Financing

FY 2020–2021 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

November 2021

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

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management (PCCM) entities, and prepaid ambulatory health plans (PAHPs) (collectively referred to as "health plans") for the administration of Medicaid programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality and timeliness of, and access to, services provided by the contracted health plans. Revisions to the regulations articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care regulations. The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438. To meet these requirements, the Colorado Department of Health Care Policy and Financing (the Department) has contracted with Health Services Advisory Group, Inc. (HSAG).

HSAG recognizes that EQR-related activities in fiscal year (FY) 2020–2021 were conducted during the unprecedented coronavirus disease 2019 (COVID-19) pandemic; therefore, results and recommendations, particularly in the access to care domain, should be considered with caution. Regardless, while some health plans experienced lower scores across domains of care, Colorado's Medicaid health plans also found innovative and creative ways to address barriers to providing a quality product for Colorado's Medicaid members.

Colorado's Medicaid Managed Care Program

Health First Colorado, Colorado's Medicaid program, is comprised of seven Regional Accountable Entities (RAEs) and two MCOs. In 2011, 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 the 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 RAEs. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of FFS primary care providers and capitated behavioral health (BH) providers to ensure access to both BH and primary care for Medicaid members through one accountable entity. The RAEs meet the federal definition of both PCCM entities and PIHPs, and as such are required to comply

with Medicaid managed care regulations at 42 CFR Part 438. 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. FY 2020–2021 was the third year of RAE operations.

The MCOs provide services under a capitated contract with the Department. One MCO provides physical health (PH) primary care, physical and behavioral inpatient and outpatient services, and specialty care for a subset of Region 5 Health First Colorado members. The other MCO provides PH primary care, PH inpatient and outpatient services, and specialty care for a subset of Region 1 Health First Colorado members.

This report includes the results of EQR-related activities conducted for both the RAEs and the MCOs in FY 2020–2021. Colorado does not exempt any of its RAEs or MCOs from EQR. Colorado's Medicaid managed care health plans are as follows.

Table 1-1—Colorado Medicaid Health Plans

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.
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.
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	PH primary, inpatient, outpatient, specialty, and acute care for a subset of Region 1 RAE members.

Scope of External Quality Review Activities for the Regional Accountable Entities

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the Centers for Medicare & Medicaid Services (CMS) EQR Protocols released in October 2019.[1-1] In FY 2020–2021 HSAG conducted both mandatory and optional EQR-related activities.

The mandatory activities conducted were:

- **Validation of performance improvement projects (PIPs) (Protocol 1).** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.
- **Validation of performance measures (Protocol 2).** 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—MCOs (Protocol 2).** 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.
- **Assessment of compliance with Medicaid managed care regulations (compliance with regulations) (Protocol 3).** Compliance activities were 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 network adequacy (Protocol 4).** Each quarter, HSAG validated each health plan's self-reported compliance with minimum time and distance network requirements and collaborated with the Department to update the quarterly network adequacy reporting materials used by the health plans.

The optional activities conducted were:

- **Encounter data validation (EDV)—RAE 411 audit over-read (Protocol 5).** 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 (Protocol 5).** HSAG conducted this activity for Colorado's two MCOs. HSAG reviewed a sample of PH encounters to ensure that medical record documentation

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 15, 2021.

supported the MCOs' 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.

- **Patient-centered medical home (PCMH) CAHPS surveys—RAEs (Protocol 6).** 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—MCOs (Protocol 6).** Each MCO was responsible for conducting a CAHPS survey of its members and forwarding the results to HSAG for inclusion in this report.

Summary of FY 2020–2021 Statewide Performance by External Quality Review Activity

RAEs Providing Services Under Colorado's Accountable Care Collaborative Program

Validation of Performance Improvement Projects

Table 1-2 displays the results of the FY 2020–2021 PIP validations and summarizes how far through the four modules of the rapid-cycle PIP process each RAE progressed.

Table 1-2—Statewide PIP Results

RAE	PIP Topic	Module Status	Validation Status
Region 1—RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 2—NHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 3—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 4—HCI	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 5—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 6—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 7—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2020–2021 validation cycle.*

During this validation cycle, the RAEs initiated new PIPs and completed Module 1 and Module 2 for the rapid-cycle PIP process. During FY 2020–2021, the RAEs received training and technical assistance on

the rapid-cycle PIP process, supporting the RAEs in developing the foundation of the projects in the first two modules of the process. The duration of the rapid-cycle PIPs is approximately 18 months, from initial submission of the first module through completion of the fourth and final module; therefore, the current PIPs will continue into the next fiscal year.

Statewide Strengths Related to Validation of Performance Improvement Projects for RAEs

The RAEs successfully initiated new rapid-cycle PIPs in FY 2020–2021 to address the state-mandated topic, *Depression Screening and Follow-Up After a Positive Depression Screen,* which focuses on concurrently improving quality, access, and timeliness of two interconnected behavioral health services: increasing the percentage of eligible members who receive a depression screen and increasing the percentage of members who screen positive for depression that receive follow-up behavioral health services within 30 days. During FY 2020–2021, all RAEs completed the first two modules of the rapid-cycle PIP process, achieving all validation criteria for Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, the RAEs established the PIP team, defined the eligible PIP population, defined the PIP measures, analyzed baseline data, and set specific and measurable goals for improving the stated goal of the PIP. In Module 2, the RAEs used quality improvement (QI) science-based tools to analyze process gaps, failure modes, and barriers to achieving improvement and identifying potential interventions to address the high-priority areas of need. Many of the RAEs engaged external partners in the work on Module 1 and Module 2 to provide insights from the provider or facility level and provide a foundation for small-scale testing of interventions that can be ramped up over time as the project progresses.

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

Although all RAEs successfully completed modules 1 and 2 of the new *Depression Screening and Follow-Up After a Positive Depression Screen* PIP during FY 2020–2021, HSAG identified two statewide opportunities for improvement while validating these modules and providing technical assistance. First, HSAG observed variation in the QI capacity, skills, and resources available to PIP teams across the different RAEs. While some RAEs were able to readily apply the rapid-cycle PIP QI tools and processes to support PIP initiation and intervention determination activities, other RAEs required more extensive technical assistance and took longer to progress through the modules. The longer a RAE takes to pass the first three modules of the rapid-cycle PIP progress, the less time remains for the RAE to test interventions and work toward achieving improvement goals. To address this opportunity, HSAG recommends that the Department work with the RAEs to support adequate QI capacity, skills, and resources for each RAE to support current and future PIPs. A second opportunity for improvement was identified specifically related to the new state-mandated PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*. During the FY 2020–2021 validation of modules 1 and 2, HSAG noted that many RAEs reported challenges in accessing accurate and complete administrative data from providers on depression screening and behavioral health follow-up services. RAEs reported that they must first address the data accuracy and completeness to determine true performance levels before working on interventions to improve performance. HSAG recommends that the Department work with the RAEs to identify specific high-impact barriers to collecting and distributing accurate and complete data and work collaboratively toward solutions for those barriers.

Validation of Performance Measures

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 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.

Performance Measure Results

Table 1-3 shows the FY 2020–2021 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 2020–2021 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

Table 1-3—Statewide Averages for the RAEs

Performance Measure	FY 2018–2019 Rate	FY 2019–2020 Rate	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment			
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.64%	38.84%	60.52%
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%	68.71%	81.79%
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%	36.02%	50.63%
Follow-Up After a Positive Depression Screen			
Follow-Up After a Positive Depression Screen	50.16%	51.94%	65.10%
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%	19.99%	27.42%

Statewide Strengths Related to Behavioral Health Performance Measures for the RAEs

HSAG found that although the statewide average rates met none of the performance targets, all seven RAEs improved their rates from the previous year for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* measure and six of the seven RAEs had greater than a 5 percentage point increase. In addition, in FY 2019–2020, the statewide average rates increased for the other four incentive measures as compared to FY 2018–2019, although not statistically significant.

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

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 behavioral health 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 practices while all RAEs collaborate on program-wide 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.

Assessment of Compliance With Medicaid Managed Care Regulations

In FY 2020–2021, HSAG reviewed four standards as directed by the Department (see Methodology in Section 2).

Table 1-4 displays the statewide average compliance monitoring results for the FY 2020–2021 assessment of compliance with regulations activity.

Table 1-4—Compliance With Regulations—Statewide Performance for the RAEs

Standard	Statewide Average—FY 2020–2021
Standard VII—Provider Participation (Selection) and Program Integrity	97%
Standard VIII—Credentialing and Recredentialing	98%
Standard IX—Subcontractual Relationships and Delegation	89%
Standard X—Quality Assessment and Performance Improvement	100%

For the seven RAEs providing services under Colorado's ACC Program, the RAEs demonstrated high overall performance in three of the four standards, with Standard VII—Provider Participation (Selection) and Program Integrity, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement scoring 97 percent, 98 percent, and 100 percent compliance, respectively. Standard IX—Subcontractual Relationships and Delegation demonstrated

moderate to high scores at 89 percent with some RAEs in compliance with only three of the four requirements in this standard, which was updated in 2016. As this is the first year that the seven RAEs have been scored on these four standards, the high average scores highlight the RAEs' ability to accurately understand the requirements and implement procedures to demonstrate compliance with the regulations within these standards. For individual RAE scores and findings, see Section 3. For the RAE comparison of scores for FY 2020–2021 standards, see Section 4, Table 4-4.

Table 1-5 displays the statewide average compliance monitoring results and the year that each standard area was reviewed. As the RAEs began their contracts with the Department in FY 2018–2019, and FY 2020–2021 was the third year of RAE operations, no statewide comparison to previous results for the standards is available.

Table 1-5—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 (Includes Confidentiality) (2018–2019)	98%
Standard V—Member Information (2018–2019)	92%
Standard VI—Grievance and Appeal Systems (2019–2020)	79%
Standard VII—Provider Participation (Selection) and Program Integrity (2020–2021)	**97%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	**98%**
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	**89%**
Standard X—Quality Assessment and Performance Improvement (2020–2021)	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)	88%

Bold text indicates standards that HSAG reviewed during FY 2020–2021.

In FY 2020–2021, the third year of RAE operations, HSAG reviewed four standard areas. The statewide average score in three of the four standard areas reached over 90 percent compliance, indicating a strong understanding of most federal regulations related to these three standards. Standard IX—Subcontractual Relationships and Delegation demonstrated a statewide average of 89 percent, indicating an opportunity for the RAEs to improve understanding of federal and State requirements related to this content area.

Statewide Strengths Related to Compliance With Regulations for the RAEs

Provider Participation (Selection) and Program Integrity:

- The RAEs used a mixture of standardized software and reporting tools within the provider network support and program integrity departments alongside manual checks as a basis to ensure appropriate provider monitoring.
- Many RAEs used streamlined risk assessment tools to monitor, identify, plan, and mitigate fraud, waste, and abuse.
- The RAEs had developed multi-tiered compliance committees to ensure information sharing at the staff, management, and leadership levels.

Credentialing and Recredentialing:

- Most RAEs demonstrated compliance with all credentialing and recredentialing requirements. All RAE sample records were compliant with standards.
- While systems and levels of sophistication varied among the RAEs, each RAE maintained the ability to track providers through the application, credentialing, and onboarding processes.
- All RAEs engaged providers with regular opportunities for training and structured communications.
- Credentialing review committees for each RAE included a variety of specialists who were able to conduct peer reviews.

Subcontractual Relationships and Delegation:

- Each RAE maintained delegate agreements with provisions that articulated the RAE's ultimate accountability for delegated responsibilities.
- Although levels of specificity varied, each RAE had means of monitoring delegates' performance through regular reporting, inter-agency meetings, and annual oversight procedures as necessary.

Quality Assessment and Performance Improvement (QAPI):

- The RAE QAPI programs demonstrated detailed work plans, program evaluations, and methods to monitor services provided for quality of care.
- The RAEs had effective mechanisms to analyze data and monitor for over- and underutilization.
- The RAEs had mechanisms to ensure improved health outcomes for members with special health care needs.
- The RAEs regularly reviewed and updated clinical practice guidelines.
- The RAEs had detailed workflows depicting health information system (HIS) configurations and provided evidence of HIS capabilities for robust reporting related to all HIS requirements.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations for the RAEs

Some RAE delegation agreements did not include the right for the Health and Human Services Office of the Inspector General (HHS-OIG), Comptroller General, or other designee to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years.

Validation of Network Adequacy

HSAG collaborated with the Department to update quarterly network adequacy reporting materials originally implemented in January 2020. Each quarter, the RAEs used the standardized templates to report narrative descriptions and geoaccess compliance results for time and distance analysis and ratios of practitioners to members. HSAG conducted quarterly network adequacy validation (NAV) analyses of the Medicaid networks among the following domains for the RAEs: Primary Care, Prenatal Care, Women's Health Services, and Behavioral Health.

The data-related findings in this report align with HSAG's validation of the RAEs' FY 2020–2021 Quarter 2 network adequacy reports, representing the measurement period reflecting the RAEs' networks from October 1, 2020, through December 31, 2020. The Department publishes the RAEs' quarterly network adequacy reports at https://hcpf.colorado.gov/accountable-care-collaborative-deliverables.

Overall, no RAE met all network standards across all counties in each county designation. In general, failure to meet the minimum time and distance network requirements was largely attributable to instances in which the closest network locations were outside the minimum time and distance requirement. However, for a RAE to meet the minimum network requirements outlined in its contract with the Department, the RAE must ensure that its network is such that 100 percent of its enrolled members have addresses within the minimum network requirements (i.e., a 100 percent access level). For example, the RAEs in urban counties (e.g., Denver County) must ensure that at least two family practitioners are within 30 miles or 30 minutes of 100 percent of each RAE's applicable members. As a result, a RAE's failure to meet a minimum network requirement does not necessarily reflect a network concern, and the RAE may employ alternate methods for ensuring members' access to care (e.g., the use of telehealth).

Statewide Strengths Related to Validation of Network Adequacy

All RAEs participated in the quarterly NAV, but no RAE-specific strengths are noted as a result of limitations related to the RAEs' network data quality and the stringency of the existing minimum time and distance network requirements.

To facilitate the Department's use of the quarterly NAV results, the Department and HSAG collaborated to develop and deploy web-based interactive dashboards displaying and stratifying NAV results by RAE, network category, and county. Furthermore, the Department responded to the results of the

FY 2020–2021 NAV analysis by implementing the following QI efforts in collaboration with HSAG during FY 2021–2022:

- Develop and implement web-based dashboards to supply detailed network data quality results to each RAE, to support improved network data quality.
- Use the RAEs' quarterly NAV reports and data to reevaluate the minimum time and distance network requirements.
- Review and update the processes and templates by which the RAEs may request that the Department grant an exception to minimum network requirements.

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

Based on the quarterly NAV results for the RAEs, HSAG offered the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the RAEs' compliance with network adequacy contract requirements and the provision of high-quality network data:

- **Enhance Network Data Quality**: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. Each RAE will be expected to use the detailed data quality results to improve the quality of their quarterly member and network data submissions to the Department.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the RAEs' networks through the development and implementation of standardized quarterly network adequacy reporting materials. The Department has directed its EQRO to conduct the following activities during FY 2021–2022:
  - An evaluation of the existing process(es) by which the RAEs are directed to request and receive exceptions to network requirements. If supported by the evaluation findings, the Department may consider standardizing the RAE exception request documentation and processes to ensure uniform review and documentation of the RAEs' network exceptions.
  - An evaluation of the appropriateness of the minimum time and distance network requirements in the RAEs' contracts with the Department. The evaluation may also consider the extent to which the RAEs offer alternate service delivery mechanisms to ensure members' access to care when minimum time or distance requirements may not be appropriate based on the geography and/or network category. For example, the Department may consider the extent to which a RAE offers and ensures that members are able to use telehealth modalities to obtain behavioral health services when practitioners are not available in rural or frontier counties.
- **Expand Network Adequacy Evaluation**: To further assess network availability, the Department should review ways to evaluate the RAEs' compliance with contract network requirements for access to care, including the following:
  - Future access to care evaluations may incorporate the RAEs' encounter data to assess members' utilization of services and potential gaps in access to care resulting from limited network availability.

- The Department may also consider conducting an independent network directory review to verify that the RAEs' publicly available network data accurately represent the network data available to the RAEs' members and align with the network data supplied to the Department for the quarterly network adequacy compliance reporting.
- In addition to assessing the number, distribution, and availability of the RAEs' network locations, the Department may choose to review member satisfaction survey results and grievance and appeals data to identify results and complaints related to members' access to care. Survey results and grievance and appeals data may 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 RAE's limited network availability.

Encounter Data Validation—RAE 411 Audit Over-Read

HSAG conducted the EDV over-read for seven RAE regions providing capitated BH services within the ACC Program. Each RAE used guidelines developed by 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 1-6 presents the RAEs' self-reported encounter data service coding accuracy results by BH service category and validated data element.

Table 1-6—RAEs' Aggregated, Self-Reported EDV Results by Data Element and BH Service Category

Data Element	Inpatient Services (614 Cases)	Ambulatory Inpatient Services (345 Cases)	Psychotherapy Services (959 Cases)	Residential Services (959 Cases)
Procedure Code	NA	95.1%	69.7%	91.1%
Principal Surgical Procedure Code	97.1%	NA	NA	NA
Diagnosis Code	89.4%	88.4%	79.5%	94.3%
Place of Service	NA	94.2%	78.4%	93.5%
Service Category Modifier	NA	94.8%	69.6%	91.2%
Units	NA	95.9%	87.0%	97.0%
Revenue Code	94.0%	NA	NA	NA
Discharge Status	97.4%	NA	NA	NA
Service Start Date	96.1%	95.9%	88.0%	97.2%
Service End Date	96.6%	95.9%	88.0%	97.1%
Population	NA	95.9%	87.8%	97.3%
Duration	NA	95.9%	83.8%	97.1%
Staff Requirement	NA	95.7%	86.3%	94.0%

NA indicates that a data element was not evaluated for the specified service category.

HSAG overread a sample of each RAE's EDV findings and tabulated agreement results that could range from 0.0 percent to 100 percent, where 100 percent represents perfect agreement between the RAE's EDV results and HSAG's over-read results, and 0.0 percent represents complete disagreement.

Table 1-7 presents, by BH service category, the percentage of cases in which HSAG's over-read results agreed with the RAEs' aggregated EDV results for each of the validated data elements.

Table 1-7—Statewide Aggregated Encounter Over-Read Agreement Results for RAEs by BH Service Category

BH Service Category	Inpatient Services (44 Over-Read Cases)	Ambulatory Inpatient Services (26 Over-Read Cases)	Psychotherapy Services (70 Over-Read Cases)	Residential Services (70 Over-Read Cases)
Procedure Code	NA	96.2%	91.4%	94.3%
Principal Surgical Procedure Code	100%	NA	NA	NA
Diagnosis Code	97.7%	96.2%	97.1%	95.7%
Place of Service	NA	23.1%	100%	97.1%
Service Category Modifier	NA	38.5%	94.3%	97.1%
Units	NA	96.2%	100%	98.6%
Revenue Code	95.5%	NA	NA	NA
Discharge Status	70.5%	NA	NA	NA
Service Start Date	95.5%	96.2%	100%	98.6%
Service End Date	95.5%	96.2%	100%	97.1%
Population	NA	96.2%	100%	98.6%
Duration	NA	96.2%	98.6%	98.6%
Staff Requirement	NA	96.2%	95.7%	95.7%

NA indicates that a data element was not evaluated for the specified service category.

Statewide Strengths Related to RAE 411 Audit Over-Read

In general, when key data elements were present in both the encounter data and the medical records, and were evaluated independently, EDV over-read results suggest a high level of confidence that the RAEs' independent validation findings accurately reflect their encounter data quality, with the exception of the *Discharge Status* data element for Inpatient Services cases and the *Place of Service* and *Service Category Modifier* data elements for Ambulatory Inpatient Services cases.

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

FY 2020–2021 is the second 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 allow the RAEs and the Department to monitor QI within the RAEs' BH encounter data. Based on the EDV and over-read results, HSAG recommends that the Department collaborate with the RAEs to identify best practices

regarding provider education to support service coding accuracy. Identifying such practices may involve the Department requesting and reviewing copies of the RAEs' provider training and/or corrective action documentation, reviewing the RAEs' policies and procedures for monitoring providers' BH encounter data submissions, and verifying that the RAEs are routinely monitoring encounter data quality beyond the annual RAE 411 EDV.

PCMH CAHPS Surveys

Table 1-8 shows the FY 2018–2019 through FY 2020–2021 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	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	63.6%	59.1%	68.0%
Rating of Specialist Seen Most Often	62.3%	63.7%	65.9%
Rating of All Health Care	59.1%	55.8%	64.0%
Rating of Health Plan	60.3%	61.3%	65.8%
Getting Timely Appointments, Care, and Information	47.7%	44.6%	49.0%
How Well Providers Communicate with Patients	73.9%	71.4%	76.2%
Providers' Use of Information to Coordinate Patient Care	61.8%	58.7%	63.3%
Talking with You About Taking Care of Your Own Health	48.9%	48.0%	50.3%
Comprehensiveness	52.8%	51.0%	53.5%
Helpful, Courteous, and Respectful Office Staff	69.1%	68.6%	69.2%
Health First Colorado Customer Service	62.6%	63.5%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	27.3%	23.2%	25.9%
Reminders About Care from Provider Office	71.6%	71.0%	73.3%
Saw Provider Within 15 Minutes of Appointment	38.4%	38.0%	43.1%
Receive Health Care and Mental Health Care at Same Place	57.6%	60.4%	62.3%

**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 provider practice.*

Due to differences in the population of selected practices from year to year, the Colorado RAE aggregate results presented in this report are not comparable across years; therefore, the above table does not represent trending, but only results for three years from different sets of providers.

Table 1-9 shows the FY 2018–2019 through FY 2020–2021 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	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	76.0%	71.8%	79.7%
Rating of Specialist Seen Most Often	74.0%	78.0%	70.3%
Rating of All Health Care	74.3%	72.0%	79.2%
Getting Timely Appointments, Care, and Information	66.2%	57.3%	67.7%
How Well Providers Communicate with Child	80.6%	79.3%	80.0%
How Well Providers Communicate with Parents or Caretakers	81.9%	78.3%	83.5%
Providers' Use of Information to Coordinate Patient Care	74.7%	70.7%	74.8%
Comprehensiveness—Child Development	65.7%	65.5%	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	58.2%	61.0%	61.8%
Helpful, Courteous, and Respectful Office Staff	69.3%	65.0%	69.6%
Received Information on Evening, Weekend, or Holiday Care	80.9%	78.6%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	32.1%	33.1%	43.1%
Reminders About Child's Care from Provider Office	67.9%	69.1%	69.7%
Saw Provider Within 15 Minutes of Appointment	42.1%	36.6%	46.5%

**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 provider practice.*

Due to differences in the population of selected practices, the Colorado RAE aggregate results presented in this report are not comparable across years; therefore, the above table does not represent trending, but only results for three years from different sets of providers.

Statewide Strengths Related to PCMH CAHPS Surveys

Adult

For the adult population, the following three measures had the highest FY 2020–2021 scores compared to the other measures' scores:

- *How Well Providers Communicate with Patients* (76.2 percent)
- *Reminders About Care from Provider Office* (73.3 percent)
- *Helpful, Courteous, and Respectful Office Staff* (69.2 percent)

Child

For the child population, the following three measures had the highest FY 2020–2021 scores compared to the other measures' scores:

- *How Well Providers Communicate with Parents or Caretakers* (83.5 percent)
- *Received Information on Evening, Weekend, or Holiday Care* (81.6 percent)
- *How Well Providers Communicate with Child* (80.0 percent)

Statewide Opportunities for Improvement and Recommendations Related to PCMH CAHPS Surveys

Adult

For the adult population, the following three measures had the lowest FY 2020–2021 scores compared to the other measures' scores:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (25.9 percent)
- *Saw Provider Within 15 Minutes of Appointment* (43.1 percent)
- *Getting Timely Appointments, Care, and Information* (49.0 percent)

Child

For the child population, the following three measures had the lowest FY 2020–2021 scores compared to the other measures' scores:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (43.1 percent)
- *Saw Provider Within 15 Minutes of Appointment* (46.5 percent)
- *Comprehensiveness—Child Safety and Healthy Lifestyles* (61.8 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.

For additional information about PCMH CAHPS results for FY 2020–2021, refer to the Medicaid aggregate CAHPS report found on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

MCOs Providing Services Under Colorado's Accountable Care Collaborative Program

Validation of Performance Improvement Projects

Table 1-10 displays the results of the FY 2020–2021 PIP validations and summarizes how far through the five modules of the rapid-cycle PIP process each MCO progressed.

Table 1-10—Statewide PIP Results

MCO	PIP Topic	Module Status	Validation Status
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
RMHP Prime	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2020–2021 validation cycle.*

During this validation cycle, the MCOs initiated new PIPs and completed Module 1 and Module 2 of the rapid-cycle PIP process. During FY 2020–2021, the primary PIP activities included MCOs receiving training and technical assistance on the rapid-cycle PIP process and developing the foundation of the projects in the first two modules of the process. The duration of the rapid-cycle PIPs is approximately 18 months, from initial submission of the first module through completion of the final module; therefore, the current PIPs will continue into the next fiscal year.

Statewide Strengths Related to Validation of Performance Improvement Projects for the MCOs

The MCOs successfully initiated new PIPs in FY 2020–2021 and achieved all validation criteria for Module 1—PIP Initiation and Module 2—Intervention Determination of the rapid-cycle PIP process. In Module 1, the MCOs established the PIP team, defined the eligible PIP population, defined the PIP measures, analyzed baseline data, and set specific and measurable goals for improving the stated goal of the PIP. In Module 2, the MCOs used QI science-based tools to analyze process gaps, failure modes, and barriers to achieving improvement and identifying potential interventions to address the high-priority areas of need. The MCOs also engaged external partners in the work on Module 1 and Module 2 to provide insights from the provider or facility level and provide a foundation for small-scale testing of interventions that can be ramped up over time as the project progresses.

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

Although both MCOs successfully completed modules 1 and 2 of the new *Depression Screening and Follow-Up After a Positive Depression Screen* PIPs during FY 2020–2021, HSAG identified one statewide opportunity (related to the MCOs) for improvement while validating these modules and providing technical assistance. The opportunity for improvement was specifically related to the new state-mandated PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*. During the FY 2020–2021 validation of modules 1 and 2, HSAG noted that both MCOs reported challenges in accessing accurate and complete data from providers on depression screening and behavioral health follow-up services. HSAG recommends that the Department work with the MCOs to identify specific high-impact barriers to collecting and distributing accurate and complete data and work collaboratively toward solutions for those barriers.

HEDIS Measure Rates and Validation

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 (PMV) performed by the MCOs' licensed HEDIS auditor. During review of the IS standards, the MCOs' licensed 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 from both MCOs followed NCQA HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

Table 1-11 and Table 1-12 display the Medicaid statewide weighted averages for HEDIS measurement year (MY) 2018 through HEDIS MY 2020, along with the percentile ranking for each HEDIS MY 2020 rate.[1-2] HSAG compared statewide performance measure results for HEDIS MY 2020 to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2019 when available. Additionally, rates for HEDIS MY 2020 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for HEDIS MY 2020

[1-2] High-performing measure rates are those ranked at or above the national Medicaid 75th percentile without a significant decline in performance from HEDIS MY 2019 or ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2019. Low-performing measure rates are those below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2019 for the MCOs (DHMP and RMHP Prime).

shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-3] Additional Medicaid statewide weighted average measure rates are found in Section 4.

Table 1-11—MCO Statewide Weighted Averages—HEDIS MY 2020 High-Performing Rates

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Counseling for Physical Activity—Total	5.81%	7.96%	68.02%^	50th–74th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.23%	0.30%	0.11%	≥90th
Living With Illness				
Statin Therapy for Patients With Cardiovascular Disease[1]				
Statin Adherence 80%—Total	64.89%	77.24%	77.18%	75th–89th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	72.28%	75.08%	78.17%	75th–89th
Antibiotic Stewardship				
Appropriate Treatment for Upper Respiratory Infection				
Total	—	94.30%	94.92%	≥90th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Total	—	63.56%	67.31%	≥90th
Antibiotic Utilization*				
*Average Scripts PMPY** for Antibiotics of Concern—Total*	0.14	0.14	0.17	≥90th
Average Scripts PMPY for Antibiotics—Total	0.41	0.43	0.50	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	33.58%	33.48%	33.64%	75th–89th
Opioids				
Use of Opioids From Multiple Providers**[1]				
Multiple Pharmacies	8.23%	3.73%	2.66%	75th–89th
Multiple Prescribers	22.10%	39.96%	14.92%^	75th–89th

[1-3] 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 MY 2019 rates may be understated or overstated.

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	49.10	49.97	38.36	≥90th
Inpatient Utilization—General Hospital/Acute Care				
Total Average Length of Stay (Medicine)	4.01	3.95	4.46	75th–89th

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

Statewide Strengths Related to HEDIS Measure Rates and Validation

The HEDIS MY 2020 statewide weighted averages for measures within the Pediatric Care and Preventive Screening domains are primarily representative of DHMP's performance, as RMHP Prime's child members include only children with disabilities in six counties in western Colorado. DHMP demonstrated strong performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator, which demonstrated statistically significant improvement in MY 2020. Additionally, within the Preventive Screening domain, 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 Living With Illness domain, the HEDIS MY 2020 statewide weighted average for the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator exceeded the 75th percentile, with RMHP Prime's rate exceeding the 90th percentile for the measure indicator. Conversely, DHMP's rate did not exceed the 50th percentile. Statewide performance for the *Use of Imaging Studies for Low Back Pain* also exceeded the 75th percentile.

The HEDIS MY 2020 statewide weighted average for measures within the Antibiotic Stewardship domain demonstrated strong performance, with two measure indicators exceeding the 90th percentile.

The HEDIS MY 2020 statewide weighted average for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure indicator in the Opioids domain exceeded the 75th percentile and demonstrated a statistically significant improvement in performance from the previous year, indicating a strength related to members receiving opioids from four or more pharmacies throughout the measurement period.

Table 1-12—MCO Statewide Weighted Averages—HEDIS MY 2020 Low-Performing Rates

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	68.01%	69.46%	68.48%	10th–24th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	76.40%	77.63%	75.51%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	21.62%	24.76%	64.36%^	10th–24th
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	62.81%	70.45%^	<10th
Postpartum Care	—	50.88%	51.65%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	61.75%	63.01%	**59.08%^^**	<10th
Preventive Screening				
Breast Cancer Screening[1]				
Breast Cancer Screening	48.53%	47.09%	**43.82%^^**	<10th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	42.52%	42.52%	40.72%	<10th
Living With Illness				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing[1]	83.24%	83.74%	**79.55%^^**	<10th
*HbA1c Poor Control (>9.0%)**[1]	56.98%	56.95%	**61.43%^^**	<10th
HbA1c Control (<8.0%)[1]	34.71%	35.37%	**31.50%^^**	<10th
Eye Exam (Retinal) Performed[1]	47.83%	47.75%	**42.09%^^**	<10th
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	52.77%	53.27%	55.10%	10th–24th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	68.18%	66.31%	66.67%	<10th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	47.02%	50.88%	50.42%	<10th
Bronchodilator	67.02%	66.43%	66.32%	<10th
Asthma Medication Ratio				
Total	49.08%	47.31%	51.56%	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits—Total	239.73	254.83	216.06	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Maternity)	2.15	2.21	1.95	10th–24th
Total Average Length of Stay (Maternity)	2.56	2.47	2.48	10th–24th

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

For HEDIS MY 2020, DHMP and RMHP Prime continued to demonstrate low performance for measures related to comprehensive 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*.[1-4]

Within the Access to Care domain, the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator demonstrated a statistically significant decline in performance from the previous year. Rates for both DHMP and RMHP Prime fell below the 10th percentile for this measure indicator. The measures related to preventive screenings for women (*Breast Cancer Screening* and *Cervical Cancer Screening*) for DHMP and RMHP Prime also fell below the 10th percentile, with statewide performance for the *Breast Cancer Screening* measure demonstrating a statistically significant decline in performance from the previous year.

Five of nine (55.5 percent) measure rates within the Living With Illness domain determined to be low-performing rates for HEDIS MY 2020 are related to the appropriate prescribing of and/or monitoring of members prescribed long-term medications. The HEDIS MY 2020 statewide weighted average for the four *Comprehensive Diabetes Care* measure indicators that could be compared to national percentiles fell below the 10th percentile and demonstrated statistically significant declines in performance from the previous year. This result demonstrates an opportunity for improvement related to members with diabetes for type 1 and type 2 receiving HbA1c and eye exam testing, and properly controlling HbA1c levels.

[1-4] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Oct 15, 2021.

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

Based on performance measure results, HSAG recommends that the Department and the MCOs evaluate some of the ongoing interventions that they have established. For example, both MCOs created interventions about diabetes care specifically targeting eye exams and HbA1c control. The Department and the MCOs should determine how effective these interventions have been over time. Specifically, HSAG recommends that the Department monitor whether RMHP Prime has received any feedback on how successful their social media, phone outreach, and mailing campaigns have been and how effective DMHP's rollout of retinal cameras in the primary care clinics has been in improving access for members and contributing to overall improvement in exam rates. In addition, it may be important for the Department and the MCOs to determine how much change in rates can be attributed to the COVID-19 public health emergency having an impact on members being able to complete their exams in person, and whether members were able to complete any visits through telehealth visits or other means.

Related to substantially low performance in the Preventive Screening domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to determine how successful the interventions have been that were recently implemented. Both MCOs created interventions related to the *Breast Cancer Screening* measure. HSAG recommends that the Department investigate if the MCOs have seen any improvement since the mailing campaigns were created and how effective RMHP Prime's Maternity and Women's Care Quality Improvement Committee (QIC) subcommittee has been in providing education to its members.

Related to low statewide scores in relation to immunizations, HSAG recommends that the Department and DHMP monitor immunizations in the school-based health centers (SBHCs) to determine how effective immunizations for children and adolescents have been in the program. Additionally HSAG recommends monitoring how successful the MCO's birthday postcard reminders and other mailing outreach efforts have been in reminding parents to schedule well-care visits and educating parents on what to expect during upcoming well-care visits. COVID-19 likely had an impact on the low rates for immunizations, but other factors could have contributed as well.

Assessment of Compliance With Medicaid Managed Care Regulations

Table 1-13 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.

Table 1-13—Compliance With Regulations—Statewide Trended Performance for the MCOs

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 (Includes Confidentiality) (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 (Selection) and Program Integrity (2017–2018, 2020–2021)	**86%**	**97%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2020–2021)	**99%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**50%**	**75%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2020–2021)	**94%**	**97%**
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 2020–2021.

The statewide average scores (based on the two MCOs) demonstrated improved performance in the most recent year of review for six of the 11 standards as compared to the previous review cycle. In two standards (Standard VII—Provider Participation (Selection) and Program Integrity and Standard IX—Subcontractual Relationships and Delegation), there was significant improvement noted (10 percentage points or more) during FY 2020–2021, as compared to the previous year reviewed (FY 2017–2018), with the most significant improvement (25 percentage points) seen in Standard IX—Subcontractual Relationships and Delegation. A slight increase (9 percentage points or fewer) was noted in the other two of the standards reviewed in FY 2020–2021. For individual MCO scores and findings, see Section 3 of this report. For the health plan comparison of scores for FY 2020–2021 standards, see Section 4, Table 4-5.

Statewide Strengths Related to Compliance With Regulations

The MCO statewide average scores indicated each plan follows NCQA credentialing guidelines and uses adequate credentialing software to validate providers joining the network and track recredentialing in a timely manner. All sample records submitted for review demonstrated 100 percent compliance for credentialing, recredentialing, and organizational provider credentialing.

Network development efforts by both MCOs included a push for telehealth expansion in CY 2020 due to the COVID-19 pandemic. Provider engagement efforts also shifted to be virtual. Compliance program activities included processes designed to identify, mitigate, and address fraud, waste, and abuse.

QAPI work plans included high-level, comprehensive details regarding measurements, successes, and ongoing improvement focus areas including goal setting.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

Some delegate agreements did not include the right for the HHS-OIG, Comptroller General, or other designee to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years.

Validation of Network Adequacy

HSAG collaborated with the Department to update quarterly network adequacy reporting materials originally implemented in January 2020. Each quarter, the MCOs used the standardized templates to report narrative descriptions and geoaccess compliance results for time and distance analysis and ratios of practitioners to members. HSAG conducted quarterly NAV analyses of the Medicaid networks among the following domains for each MCO:

- DHMP: Primary Care, Prenatal Care, Women's Health Services, Physical Health Specialists, Behavioral Health, Acute Care Hospitals, and Pharmacies
- RMHP Prime: Primary Care, Prenatal Care, Women's Health Services, Physical Health Specialists, Acute Care Hospitals, and Pharmacies

The data-related findings in this report align with HSAG's validation of the MCOs' FY 2020–2021 Quarter 2 network adequacy reports, representing the measurement period reflecting the MCOs' networks from October 1, 2020, through December 31, 2020.

Overall, neither MCO met all network standards across all counties in each county designation. In general, failure to meet the minimum time and distance network requirements was largely attributable to instances in which the closest network locations were outside the minimum time and distance requirement. However, for an MCO to meet the minimum network requirements outlined in its contract with the Department, the health plan must ensure that its network is such that 100 percent of its enrolled members have addresses within the minimum network requirements (i.e., a 100 percent access level). For example, the MCOs in urban counties (e.g., Denver County) must ensure that at least two family practitioners are within 30 miles or 30 minutes of each of the MCO's applicable members. As a result,

an MCO's failure to meet a minimum network requirement does not necessarily reflect a network concern, and the health plan may employ alternate methods for ensuring members' access to care (e.g., the use of telehealth).

Statewide Strengths Related to Validation of Network Adequacy

Both MCOs participated in the quarterly NAV, but no MCO-specific strengths are noted as a result of the limitations related to the MCOs' network data quality and the stringency of the existing minimum time and distance network requirements.

To facilitate the Department's use of the quarterly NAV results, HSAG collaborated with the Department to develop and deploy web-based interactive dashboards displaying and stratifying NAV results by health plan, network category, and county. Furthermore, the Department responded to the results of the FY 2020–2021 NAV analysis by implementing the following QI efforts in collaboration with HSAG during FY 2021–2022:

- Develop and implement web-based dashboards to supply detailed network data quality results to each health plan, to support improved network data quality.
- Use the health plans' quarterly NAV reports and data to reevaluate the minimum time and distance network requirements.
- Review and update the processes and templates by which MCOs may request that the Department grant an exception to minimum network requirements.

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

Based on the quarterly NAV results for the MCOs, HSAG offers the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the health plans' compliance with network adequacy contract requirements and the provision of high-quality network data:

- **Enhance Network Data Quality**: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. Each MCO will be expected to use the detailed data quality results to improve the quality of their quarterly member and network data submissions to the Department.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the MCOs' networks through the development and implementation of standardized quarterly network adequacy reporting materials. The Department has directed its EQRO to conduct the following activities during FY 2021–2022:
  - An evaluation of the existing process(es) by which the MCOs are directed to request and receive exceptions to network requirements. If supported by the evaluation findings, the Department may consider standardizing the MCO exception request documentation and processes to ensure uniform review and documentation of the MCOs' network exceptions.

  - An evaluation of the appropriateness of the minimum time and distance network requirements in the MCOs' contracts with the Department. The evaluation may also consider the extent to which the MCOs offer alternate service delivery mechanisms to ensure members' access to care when minimum time or distance requirements may not be appropriate based on the geography and/or network category. For example, the Department may consider the extent to which an MCO offers and ensures that members are able to use telehealth modalities to obtain behavioral health services when practitioners are not available in rural or frontier counties.

- **Expand Network Adequacy Evaluation**: To further assess network availability, the Department should review ways to evaluate the MCOs' compliance with contract network requirements for access to care, including the following:
  - Future access to care evaluations may incorporate the MCOs' encounter data to assess members' utilization of services and potential gaps in access to care resulting from limited network availability.
  - The Department may also consider conducting an independent network directory review to verify that the MCOs' publicly available network data accurately represent the network data available to the MCOs' members and align with the network data supplied to the Department for the quarterly network adequacy compliance reporting.
  - In addition to assessing the number, distribution, and availability of the MCOs' network locations, the Department may choose to review member satisfaction survey results and grievance and appeals data to identify results and complaints related to members' access to care. Survey results and grievance and appeals data may 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 an MCO's limited network availability.

Encounter Data Validation—MCO 412 Audit Over-Read

HSAG conducted the EDV over-read for Colorado's two MCOs offering services under the limited managed care capitated initiative. Each MCO used guidelines developed by 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 1-14 presents the MCOs' self-reported encounter data service coding accuracy results by service category and validated data element.

Table 1-14—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	90.80%	91.70%	89.30%	91.30%	90.80%
Through Date	90.30%	NA	NA	NA	90.30%
Primary Diagnosis Code	83.50%	89.80%	83.00%	62.10%	79.60%
Primary Surgical Procedure Code	76.20%	NA	NA	NA	76.20%
Discharge Status	85.40%	NA	NA	NA	85.40%

Data Element	Inpatient Encounters	Outpatient Encounters	Professional Encounters	FQHC Encounters	Aggregate Results
Procedure Code	NA	89.80%	82.00%	85.90%	85.90%
Procedure Code Modifier	NA	91.70%	85.00%	82.00%	86.20%
Units	NA	90.30%	86.90%	90.30%	89.20%

** Each service category has a modified denominator based on the MCO's 412 Service Coding Accuracy Report Summary.*
NA indicates that a data element was not evaluated for the specified service category.

HSAG overread a sample of each MCO's EDV findings and tabulated agreement results that could range from 0.0 percent to 100 percent, where 100 percent represents perfect agreement between the MCO's EDV results and HSAG's over-read results, and 0.0 percent represents complete disagreement. Table 1-15 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 1-15—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	40	92.50%	240	97.50%
Outpatient	40	85.00%	200	95.00%
Professional	40	100%	200	100%
FQHC	40	72.50%	200	93.00%
Total	**160**	**87.50%**	**840**	**96.40%**

** HSAG sampled 20 cases per MCO from each service category (i.e., 40 cases total per service category).*
NA indicates that a data element was not evaluated for the specified service category.

Statewide Strengths Related to MCO 412 Audit Over-Read

Results from HSAG's 412 EDV over-read suggest a moderate level of confidence for RMHP Prime and a high level of confidence for DHMP that the respective MCOs' independent validation findings accurately reflect the encounter data quality summarized in their service coding accuracy results. HSAG's review of the study documentation provided by the Department and each MCO suggests that all parties followed the guidelines while conducting the EDV.

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

The MCOs' 412 EDV results and HSAG's subsequent over-read demonstrated targeted opportunities for improvement in the MCOs' oversight of data submissions from their providers. HSAG recommends the Department collaborate with each MCO to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of the MCO's provider training and/or corrective action documentation, reviewing the MCO's policies and procedures for monitoring providers' physical health encounter data submissions, and verifying that the MCO is routinely monitoring encounter data quality beyond the annual 412 EDV.

CAHPS Surveys

Table 1-16 shows the adult statewide CAHPS results for FY 2018–2019, FY 2019–2020, and FY 2020–2021.

Table 1-16—Adult Statewide CAHPS Results for MCOs

Measure	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate	FY 2020–2021 Statewide Aggregate
Getting Needed Care	76.9%	78.4%	83.9%
Getting Care Quickly	77.9%	77.2%	80.0%
How Well Doctors Communicate	93.3%	93.9%	93.4%
Customer Service	91.6%	91.3%	90.8%
Rating of Personal Doctor	69.5%	71.7%	73.8% ↑
Rating of Specialist Seen Most Often	70.2%	71.2%	65.8%
Rating of All Health Care	56.0%	56.7%	56.4%
Rating of Health Plan	61.6%	63.4%	56.9% ↓ ▼

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Table 1-17 shows the child statewide CAHPS results for FY 2018–2019, FY 2019–2020, and FY 2020–2021.[1-5]

Table 1-17—Child Statewide CAHPS Results for MCOs

Measure	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate	FY 2020–2021 Statewide Aggregate
Getting Needed Care	78.3%	75.1%+	85.1%
Getting Care Quickly	87.2%	80.5%+	89.4%
How Well Doctors Communicate	95.4%	94.9%+	96.5%
Customer Service	86.1%	89.0%+	90.9%
Rating of Personal Doctor	85.8%	78.8%	79.5%
Rating of Specialist Seen Most Often	75.7%+	60.9%+	79.2%
Rating of All Health Care	73.5%	66.0%+	76.2%
Rating of Health Plan	73.2%	67.4%	68.7%

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

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Statewide Strengths Related to CAHPS Surveys

Adult

For the adult Medicaid population, the scores for three measures were higher in FY 2020–2021 when compared to FY 2019–2020, although not statistically significantly. However, for the adult statewide Medicaid population, one measure scored statistically significantly higher than the 2020 NCQA national average (*Rating of Personal Doctor).*

Child

The scores for each measure for the child statewide Medicaid population were higher in FY 2020–2021 when compared to FY 2019–2020 results; however, the scores were not statistically significantly higher on any measure. Overall, member experience scores for the MCOs' child population have fluctuated, either increasing or decreasing slightly, across the three-year period; however, there appears to be an upward trend for the *Customer Service* measure.

[1-5] RMHP Prime was not required to submit child Medicaid CAHPS data for reporting purposes in FY 2019–2020; therefore, the FY 2019–2020 Child Statewide Aggregate only includes CAHPS results for DHMP and is not comparable to the FY 2018–2019 and FY 2020–2021 Child Statewide Aggregates.

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

The adult statewide Medicaid population scores were statistically significantly lower in FY 2020–2021 than in FY 2019–2020 and statistically significantly lower than the 2020 NCQA national average on one measure, *Rating of Health Plan*. Since this measure is most closely associated with the quality domain of care, HSAG recommends that the Department work with the MCOs to determine what may drive low scores for this measure. For example, an assessment of customer service processes may provide additional information, as customer service is often the first contact point for members. Similarly, an assessment of utilization review turnaround times or of care coordination processes, if a large portion of members receive care coordination, may provide valuable information. The Department may want to collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of quality of care. In addition, the MCOs may want to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters.

For additional information about MCO CAHPS results for FY 2020–2021, refer to the Medicaid aggregate CAHPS report found on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

Colorado's Managed Care Quality Strategy

Health First Colorado is a unique and innovative program that combines an FFS model with features of a managed health care system for managing costs, utilization, and quality. This model was developed in an effort to create a person-centered, coordinated, community-based health care system that focuses on improving the quality of care delivered, controlling healthcare costs, and helping the most vulnerable persons thrive. Health First Colorado differs from a capitated managed care program by investing directly in community infrastructure to support care teams and care coordination. The Department assesses and evaluates performance of the program through requiring its health plans to conduct the following:

- Ongoing assessments of quality and appropriateness of care.
- Calculating and reporting national performance measures such as HEDIS and CAHPS and custom-designed HEDIS-like measures.
- Internal auditing and monitoring to detect fraud, waste, and abuse.
- Regular monitoring of the health plans' compliance programs.
- Participation in mandatory EQR activities.
- Participation in custom developed optional EQR activities designed to further specific Department goals and objectives.

The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve the quality, timeliness of, and access to care based on the Department's strategic QI goals

and associated objectives. Based on EQR findings for FY 2020–2021, HSAG recommends the following to target and improve statewide performance and achieve selected goals and objectives.

Goals, Objectives, and Statewide Recommendations

Goal 1: Enhancing Delivery System Innovation

Objectives

- Improving the members' experience of patient care.
- Promoting effective prevention and treatment of chronic disease by ensuring members are connected to the right care, at the right time, every time.
- Increasing and monitoring members' access to care and provider network adequacy.

Recommendations

- Encourage its health plans to engage in a targeted assessment of its customer service functions. This department within a health plan is typically the first contact point for members and may directly impact member perceptions of the quality of the health plan. Initiatives designed to improve customer service interactions may impact several measures related to quality and access to care.
- Encourage its health plans to assess utilization review turnaround times and communications to members related to utilization review processes. Members' perceptions of authorization processes and timeliness of authorizations may impact measures related to quality and timeliness of services provided.
- Continue to reward creative care coordination programs that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions, and assess and refer members to appropriate community partners to address social determinants of health.
- Continue to critically evaluate and refine network adequacy oversight and enhance Colorado-specific minimum network requirements to reflect Colorado's unique healthcare delivery system and geography.
- Encourage health plans to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters, to improve member understanding and engagement in healthcare and the healthcare community.

Goal 2: Improving Population Health

Objectives

- Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.
- Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care.

Recommendations

- Continue to strengthen community partnerships and encourage health plans to continue to invest in the health neighborhood.
- Use the Department's integrated quality improvement committee (IQuIC) as a forum in which the higher performing RAEs and MCOs share best practices for identifying QI goals, objectives, and interventions, as well as to collaborate on program-wide solutions to common barriers.

Goal 3: Reducing Per Capita Costs of Healthcare

Objectives

- Deliver high quality of care.
- Improve the quality of data used for performance metrics and monitoring.
- Implement pay for performance.

Recommendations

- Continue and enhance pay for performance to the RAEs and providers through per member per month (PMPM) enhanced payment for meeting key performances indicator goals.
- Continue and enhance the behavioral health incentive measure program and consider expanding or developing a similar program to improve MCO performance on physical health performance metrics.
- Continue to critically evaluate the accuracy of the health plans' encounter data by encouraging health plans to conduct ongoing quality monitoring beyond the annual EDV activities.
- Continue to collaborate with the health plans to support adequate QI capacity, skills, and resources for each RAE and MCO to support current and future PIPs.
- Formalize health plan monitoring by conducting routine health plan-specific performance review meetings that utilize formal and informal verbal and written expectation setting, performance review, and health plan response to support monitoring efforts to improve performance on targeted objectives in selected performance metrics.

2. Reader's Guide

Report Purpose and Overview

To comply with federal healthcare regulations at 42 CFR Part 438, the Department contracts with HSAG to annually provide to CMS an assessment of the State's Medicaid health plans' performance, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that HSAG conducted with the Medicaid health plans throughout FY 2020–2021.

How This Report Is Organized

Section 1—Executive Summary includes a brief introduction to Health First Colorado and describes the authority under which the report must be provided, as well as the EQR activities conducted during FY 2020–2021 with a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQR activities in FY 2020–2021. This section also includes a summary description of relevant statewide trends over a three-year period for each EQR activity as applicable, with references to the section in which the health plan-specific results can be found, where appropriate. In addition, Section 1 includes any conclusions drawn and recommendations made for statewide performance improvement, as well as an assessment of how the Department can target the goals and objectives of the State's Managed Care Quality Strategy to better support the improvement of the quality and timeliness of, and access to healthcare provided by the Medicaid health plans.

Section 2—Reader's Guide provides the purpose and overview of this annual EQR technical report; an overview of the methodology for each EQR activity performed; and how HSAG obtained, aggregated, and used the data obtained to draw conclusions as to the quality and timeliness of, and access to care provided by Colorado's Medicaid managed care health plans.

Section 3—Evaluation of Colorado's Medicaid Managed Care Health Plans provides summary-level results for each EQR-related activity performed for the RAEs and MCOs. This information is presented by health plan and provides an EQR-related activity-specific assessment of the quality of, timeliness of, and access to care and services for each health plan as applicable to the 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 2019–2020 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 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.

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.

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that any reported improvement is related, and can reasonably be linked to, the QI strategies and activities the health plans conducted during the PIP. HSAG's scoring methodology evaluated whether the health plan executed a methodologically sound PIP.

Technical Methods of Data Collection

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of Plan-Do-Study-Act (PDSA) cycles, and applying rapid-cycle learning principles over the course of the PIP to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

[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.

For this PIP framework, HSAG uses four modules with an accompanying reference guide to assist MCOs in documenting PIP activities for validation. Prior to issuing each module, HSAG holds technical assistance sessions with the MCOs to educate about application of the modules. The four modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the MCO sets aims (Global and SMART [Specific, Measurable, Attainable, Relevant, and Time-bound]), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.
- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the QI activities reasonably expected to impact the SMART Aim. The MCO updates the key driver diagram from Module 1 after completing process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking for a more in-depth understanding of the improvement strategies that are most likely to support achievement of the SMART Aim goal.
- **Module 3—Intervention Testing:** In Module 3, the MCO defines the intervention plan for the intervention to be tested, and the intervention effectiveness measure and data collection process are defined. The MCO will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, the MCO summarizes key findings, compares successful and unsuccessful interventions, and reports outcomes achieved. The MCO will synthesize data collection results, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement after the project ends.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission forms. In FY 2020–2021, these forms provided detailed information on the PIPs and the activities completed for Module 1—PIP Initiation and Module 2—Intervention Determination.

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 and technical assistance to the health plans, and the health plans resubmitted revised modules 1 and 2 until all validation criteria were achieved.

HSAG's module submission forms allowed the health plans to document the data collection methods used to obtain PIP measure results for monitoring improvement achieved through each PIP. Table 2-1 summarizes the performance indicator description and data sources used by each health plan for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIPs.

Table 2-1—*Depression Screening and Follow-Up After a Positive Depression Screen* PIP SMART Aim Statements and Data Sources

RAE	SMART Aims	Data Sources
Region 1—RMHP	By 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE Members attributed to either SMFM or MFHC age 12 years and older, from 0.8% to 20%.	Claims and enrollment data
	By 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of follow ups within 30 days of a positive depression screen among RAE Members attributed to either SMFM or MFHC age 12 years and older, from 0% to 46.89%.	Claims and enrollment data
Region 2—NHP	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC) ages 12 and up, from 84.04% to 85.06%.	Electronic health record (EHR) data on enrollment and encounters
	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC ages 12 and up, from 40.22% to 47.66%.	EHR data on enrollment and encounters, and FFS claims data
Region 3—COA	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 and older who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 86.84% to 88.72%.	Claims and enrollment data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 and older within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 56.81% to 65.76%.	Claims and enrollment data
Region 4—HCI	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older, from 11.21% to 15%.	Claims and enrollment data
	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow–ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from 25.15% to 30%.	Claims and enrollment data
Region 5—COA	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 and older who receive care at Every Child Pediatrics and Inner City Health Center from 56.39% to 61.99%.	Claims and enrollment data

RAE	SMART Aims	Data Sources
	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 and older within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Inner City Health Center from 44.18% to 70.59%.	Claims and enrollment data
Region 6—CCHA	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Clinica Family Health (Lafayette and Peoples Clinics) among CCHA members 12 years or older from 52.18% to 58.41%.	Encounter and FFS claims data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Clinica Family Health (Lafayette and Peoples Clinics) among CCHA members 12 years or older from 80.9% to 97.92%.	Encounter and FFS claims data
Region 7—CCHA	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 52.12% to 54.81%.	Encounter and FFS claims data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 90.3% to 96.7%.	Encounter and FFS claims data
MCO	**SMART Aims**	**Data Sources**
DHMP	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39%.	Enrollment data, claims data, and electronic medical record (EMR) data
	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58%.	Enrollment data, claims data, and EMR data

MCO	SMART Aims	Data Sources
RMHP Prime	By 6/30/2022, RMHP will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.3% to 20.0%.	Claims and enrollment data
	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 33.3% to 46.89%.	Claims and enrollment data

How Data Were Aggregated and Analyzed

Using its rapid-cycle PIP validation tools for each module, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element for modules 1 and 2 as *Met* or *Not Met*. A health plan must receive a *Met* score on all applicable evaluation elements for modules 1 through 3 before progressing on to the next phase of testing interventions through PDSA cycles and reporting PIP conclusions in Module 4. Once the health plan has completed intervention testing and submitted Module 4 and the completed PDSA worksheets for validation, HSAG will review the PDSA worksheet documentation and score evaluation elements for Module 4 as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG will assign a level of confidence to the PIP after completing validation of Module 4 submission.

How Conclusions Were Drawn

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 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-4]

During validation, HSAG determines if criteria for each module were *Met.* Any validation criteria not applicable were not scored. Once the PIP progresses, HSAG will use the validation findings 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 goals achieved statistically significant, clinically significant, or programmatically significant improvements for

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 15, 2021.

both measures; at least one tested intervention for each measure could reasonably result in the demonstrated improvement; and the MCO accurately summarized the key findings and conclusions.

- ***Moderate confidence*:** The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:
  - The SMART Aim goal achieved statistically significant, clinically significant, or programmatically significant improvement *for only one measure*, and the MCO accurately summarized the key findings and conclusions.
  - Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure* and the MCO accurately summarized the key findings and conclusions.
  - The SMART Aim goal achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.
- ***Low confidence:*** One of the following occurred:
  - The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.
  - The PIP was methodologically sound. The SMART Aim goal achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.
  - The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.
- ***No confidence:*** The SMART Aim measures and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

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 2-2.

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

RAE	Performance Improvement Project	Quality	Timeliness	Access
Region 1—RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Region 2—NHP (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓

RAE	Performance Improvement Project	Quality	Timeliness	Access
Region 3—COA (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Region 4—HCI (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Region 5—COA (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Region 6—CCHA (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Region 7—CCHA (PH care)	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
MCO	**Performance Improvement Projects**	**Quality**	**Timeliness**	**Access**
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
RMHP Prime	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓

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 FY 2019–2020 (i.e., July 1, 2019, through June 30, 2020) performance measures be validated during FY 2020–2021 based on the specifications outlined in the *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2019–2020*, which was written collaboratively by the

RAEs and the Department.[2-5] 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 FY 2019–2020, several measures were HEDIS-like measures, and several other measures were developed by the Department and the RAEs, collaboratively.

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 CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,[2-6] and were used to improve the efficiency of validation work performed.
- 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 virtual 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.
- 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 virtual site visit, and conducting conference calls with the Department to discuss the virtual site visit activities and to address any ISCAT-related questions.

Virtual Review Activities: HSAG conducted a virtual site visit for the Department to validate the processes used for calculating the penetration rate measures. The virtual 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

[2-5] Colorado Department of Health Care Policy and Financing. *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2019–2020.*

[2-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 15, 2021.

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 virtual review, and to revisit the documentation requirements for any post-review activities.

Description of Data Obtained

As identified in the CMS EQR Protocol 2, HSAG obtained and reviewed the following key types of data for FY 2020–2021 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 virtual 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.
- **Virtual Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Department staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG validated findings for each of the required performance measures and prepared a report for each RAE, with documentation of any identified issues of noncompliance, problematic performance measures, and recommended corrective actions. HSAG received the final rates for each RAE from the Department and compared each RAE's rates to previous years, if applicable, and also compared rate results across the RAEs to identify outliers.

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 EQR Protocol 2, 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 2-3.

Table 2-3—Performance Targets

Performance Measure	Performance Target*
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	50.63%
Follow-Up After a Positive Depression Screen	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	27.42%

*Performance targets are specified in the *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2019–2020.*

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 2-4.

Table 2-4—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	✓	✓	✓

HEDIS Measure Rates and Validation—MCOs

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 in MY 2020 (due to COVID-19) regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[2-7]

- 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.
- Virtual 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 MY 2020 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.

[2-7] 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 HEDIS MY 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 MY 2018, HEDIS MY 2019, and HEDIS MY 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 MY 2018, HEDIS MY 2019, and HEDIS MY 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.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the audited HEDIS results submitted to the Department by the two MCOs for Medicaid, which included each MCO's FAR and IDSS. HSAG used the final audit results and the FAR as the primary data sources to tabulate overall HEDIS reporting capabilities and functions for the MCOs. The final audit results provided the final determinations of validity made by the MCO's LO auditor for each performance measure. The FAR included information on the MCO's IS capabilities, findings for each measure, MRR validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement.

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 MY 2019 to HEDIS MY 2020. Rates shaded red with two carets (^^) indicate statistically significant declines in performance from HEDIS MY 2019 to HEDIS MY 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 MY 2020 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2019, when available. 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 MY 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-performing rates 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 MY 2019.
  - Ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2019.
- Low-performing rates 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 MY 2019.

Based on 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 MY 2018, HEDIS MY 2019, and HEDIS MY 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
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
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			
Child and 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 30 Months of Life	✓		✓
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services			✓
Prenatal and Postpartum Care	✓	✓	✓
Preventive Screening			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Mental/Behavioral Health			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		

Performance Measure	Quality	Timeliness	Access
Living With Illness			
Asthma Medication Ratio	✓		
Comprehensive Diabetes Care	✓		
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 (Per 1,000 Member Months)	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Plan All-Cause Readmissions	✓		

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG divided the federal regulations into 12 standards consisting of related regulations and contract requirements. Table 2-7 describes the standards and associated regulations and requirements reviewed for each standard.

Table 2-7—Compliance Standards

Standard Number and Title	Regulations Included
Standard I—Coverage and Authorization of Services	438.114 438.210
Standard II—Access and Availability	438.206 438.207
Standard III—Coordination and Continuity of Care	438.208
Standard IV—Member Rights and Protections (Includes Confidentiality)	438.100 438.224
Standard V—Member Information	438.10
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424
Standard VII—Provider Participation (Selection) and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines
Standard IX—Subcontractual Relationships and Delegation	438.230
Standard X—Quality Assessment and Performance Improvement	438.236 438.240 438.242

Standard Number and Title	Regulations Included
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280
Standard XII—Enrollment and Disenrollment	438.3(d) 438.56

For the FY 2020–2021 compliance review process, the standards reviewed were Standard VII—Provider Participation (Selection) and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. 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 credentialing and recredentialing.

Objectives

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

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

Technical Methods of Data Collection

To assess for compliance with regulations for the health plans, HSAG performed the five activities described in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[2-8] Table 2-8 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-8—Protocol Activities Performed for Assessment of Compliance With Regulations

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Due to the COVID-19 pandemic, the Department directed HSAG to conduct all compliance monitoring activities virtually. HSAG used Webex conferencing to conduct the FY 2020–2021 compliance reviews. All protocol activities, requirements, and agendas were followed. Before the virtual compliance review designed 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 reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the Webex 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 four standards and record reviews. Thirty days prior to each scheduled virtual review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the Webex portion of the 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 providers who were credentialed and recredentialed between January 1, 2020, and December 31, 2020

[2-8] 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: Oct 15, 2021.

For this step,	HSAG completed the following activities:
	(to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review. • The HSAG review team reviewed all documentation submitted prior to the Webex portion of the review and prepared a request for further documentation and an interview guide to use during the virtual review.
Activity 3:	**Conduct Virtual Compliance Review**
	• During the Webex 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 credentialing and recredentialing practices. • HSAG also requested and reviewed additional documents as needed based on interview responses. • At the close of the Webex portion of the review, HSAG met with health plan staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved compliance review report templates to compile the findings and incorporate information from compliance review activities. • HSAG analyzed the findings. • HSAG determined strengths, opportunities for improvement, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report templates. • HSAG submitted the compliance 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 (credentialing and recredentialing)
- Interviews with key health plan staff members conducted on-site or virtually via Webex

How Data Were Aggregated and Analyzed

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, the review of credentialing records provided by the health plan, virtual interviews conducted with key health plan personnel, and any additional documents submitted as a result of the interviews. HSAG then calculated scores; analyzed scores, looking for patterns of compliance and noncompliance; and compared scores to the health plans' previous performance, looking for trends. HSAG developed statewide tables of performance (see Section 4) to conduct comparisons of health plans and determine if commonalities of performance existed within the review period, and developed long-term comparison of standard scores over the three-year cycle to determine if the health plans' overall compliance improved across multiple review cycles.

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 2-9 depicts assignment of the standards to the domains of care.

Table 2-9—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

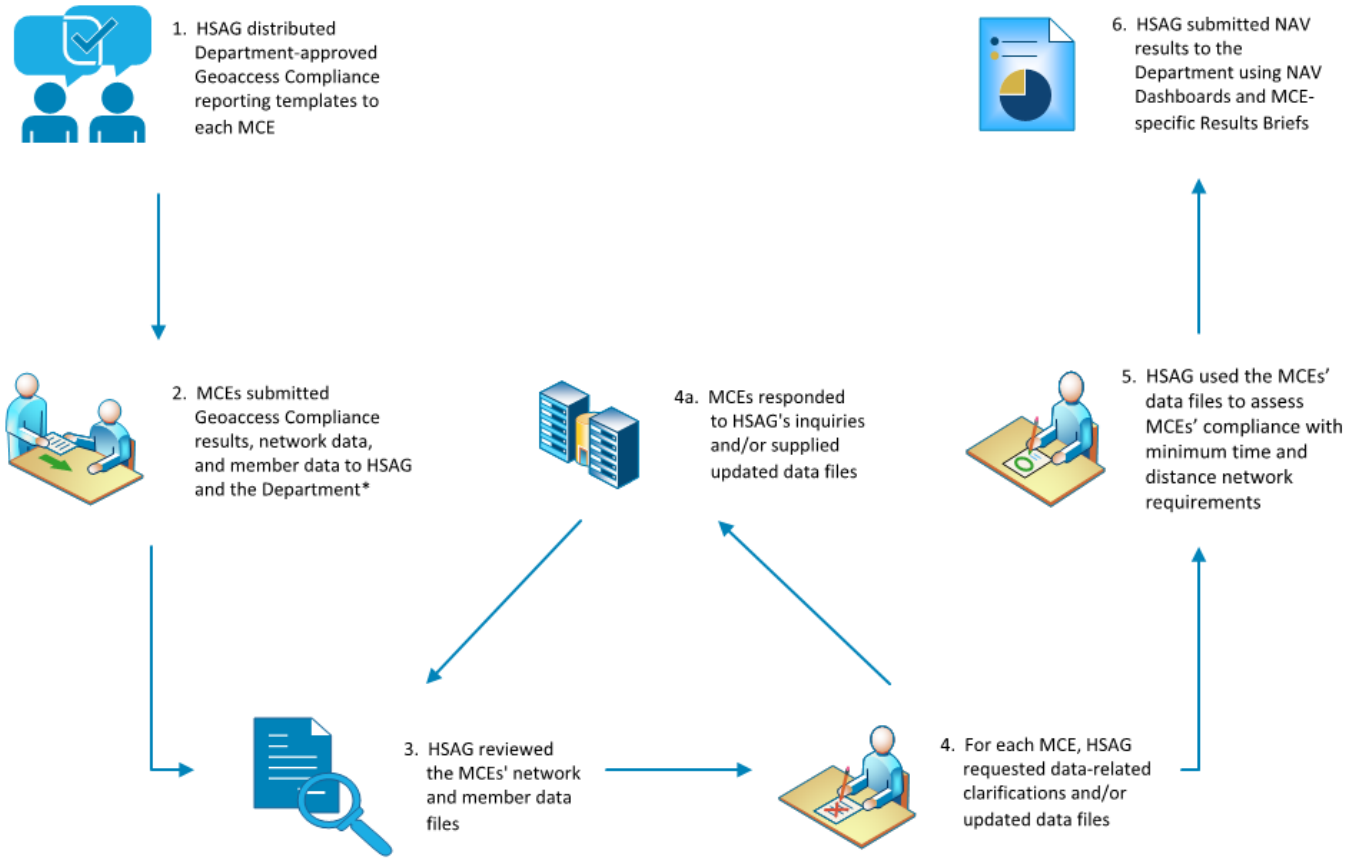
Compliance Review Standard	Quality	Timeliness	Access
Standard VII—Provider Participation (Selection) and Program Integrity		✓	✓
Standard VIII—Credentialing and Recredentialing	✓		✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Quality Assessment and Performance Improvement	✓	✓	

Validation of Network Adequacy

Objectives

The purpose of the FY 2020–2021 NAV was to determine the extent to which HSAG agreed with the health plans' (also referred to as "managed care entities [MCEs]" for the NAV activity) self-reported compliance with minimum time and distance network requirements applicable to each health plan. Beginning in the upper left corner, Figure 2-1 describes the key steps in HSAG's quarterly NAV process.

Figure 2-1—Summary of FY 2020–2021 Network Adequacy Validation Process



** HSAG's validation results reflect the health plans' member and network data submissions, and the Department also supplied network and member data to HSAG for comparison with the health plans' data.*

HSAG provided the Department-approved geoaccess compliance templates and requested network and member data from each health plan. HSAG reviewed each health plan's network and member data, iteratively requesting clarifications of data-related questions or updated data files. Once clarified and updated as needed, HSAG performed the network adequacy analyses to assess health plan compliance

with minimum time and distance standards. HSAG also developed the network adequacy dashboards for internal use by the Department in QI activities.

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 managed care Network Crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[2-9,2-10] Table 2-10 presents the network domains applicable to MCOs and RAEs; within each domain, network categories included in the FY 2020–2021 NAV analyses were limited to categories corresponding to the health plans' minimum time and distance network requirements.

Table 2-10—Network Domains by Health Plan Type

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

Technical Methods of Data Collection

Beginning in FY 2018–2019, HSAG collaborated with the Department to develop and maintain a Network Crosswalk and quarterly network adequacy reporting materials, with the goal of standardizing the health plans' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the health plans' network adequacy results. On December 30, 2020, HSAG reminded each health plan of the January 29, 2021, deadline to submit the FY 2020–2021 Quarter 2 network adequacy report and data files. Each health plan's reminder notice included detailed data requirements and a health plan-specific Network Adequacy Quarterly Geoaccess Results Report template containing the health plan's applicable network requirements and contracted counties. To support consistent network definitions across the health plans and over time, HSAG supplied the health

[2-9] 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: Oct 15, 2021.

[2-10] 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.

plans with the Department-approved June 2020 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

Concurrent with requesting the health plans' network and member data, HSAG requested Medicaid and Child Health Plan Plus (CHP+) member files from the Department using a detailed member data requirements document for members actively enrolled with a health plan as of December 31, 2020. During the FY 2020–2021 Quarter 2 NAV, HSAG used the Department's member data to assess the completeness of the health plans' member data submissions (e.g., comparing the number of members by county between the two data sources).

Description of Data Obtained

Quantitative data for the study included member-level data from the Department and member and network data files 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.

How Data Were Aggregated and Analyzed

HSAG used the health plans' member and network data to calculate time/distance and compliance mismatch results for each MCO and RAE for each county in which the health plan had at least one member identified in the health plan's member data file during FY 2020–2021 Quarter 2. HSAG evaluated two dimensions of access and availability: compliance mismatch (i.e., HSAG did not agree with the health plan's quarterly geoaccess compliance results) and geographic network distribution analysis (i.e., time and distance metrics). HSAG calculated these metrics for the network categories for which the Department identified a minimum time and distance access requirement prior to initiation of the analysis.

Prior to analysis, HSAG assessed the completeness and validity of selected data fields critical to the NAV analyses from the health plans' member and network data files. Within the health plans' network and member data files, HSAG conducted a variety of validation checks for fields pertinent to the time and distance calculations, including the following:

- Evaluating the extent of missing and invalid data values.
- Compiling the frequencies of data values.
- Comparing the current data to the health plans' prior quarterly data submissions.

HSAG also used the Department's member data to assess the completeness and reasonability of the health plans' member data files (e.g., assessing the proportion of members residing outside of a health plan's assigned counties and comparing the results to prior quarters' data). HSAG supplied each health plan with a written document summarizing the initial file review findings and stating whether clarifications and/or data file resubmissions were required.

Following the initial data review and HSAG's receipt of the health plans' data resubmissions and/or clarifications, HSAG geocoded the member and network addresses to exact geographic locations (i.e., latitude and longitude). Geocoded member and network data were assembled and used to conduct plan type-specific (MCO or RAE) analyses using the Quest Analytics Suite Version 2020.2 software (Quest). HSAG used Quest to calculate the duration of travel time or physical (driving) distance between the members' addresses and the addresses of the nearest provider(s) for the selected network categories.

Consistent with the Department's instructions to the health plans, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[2-11] HSAG used the counties listed in the health plans' member data files to attribute each member to a Colorado county for the county-level time and distance calculations (i.e., the number and percentage of members residing in the specified county with a residential address within the minimum time or distance requirement for the specific network requirement among all applicable providers, regardless of the providers' county). For health plan member records missing the county information, HSAG used the county identified by Quest if the address was an exact match during the geocoding process. Members that could not be attributed to a Colorado county were excluded from the NAV analyses.

How Conclusions Were Drawn

HSAG used the RAEs' and Medicaid MCOs' quarterly geoaccess compliance reports and provider data, and the Department's member data to perform the geoaccess analysis specific to each health plan. HSAG reviewed the results of the compliance mismatch analysis to identify the percentage of results where HSAG agreed with the health plan's geoaccess compliance results, stratified by county designation. HSAG reviewed the results of the analysis of time and distance requirement to report the percentage of results within the time and distance network requirements, and the percentage of results that did not meet the time and distance requirements.

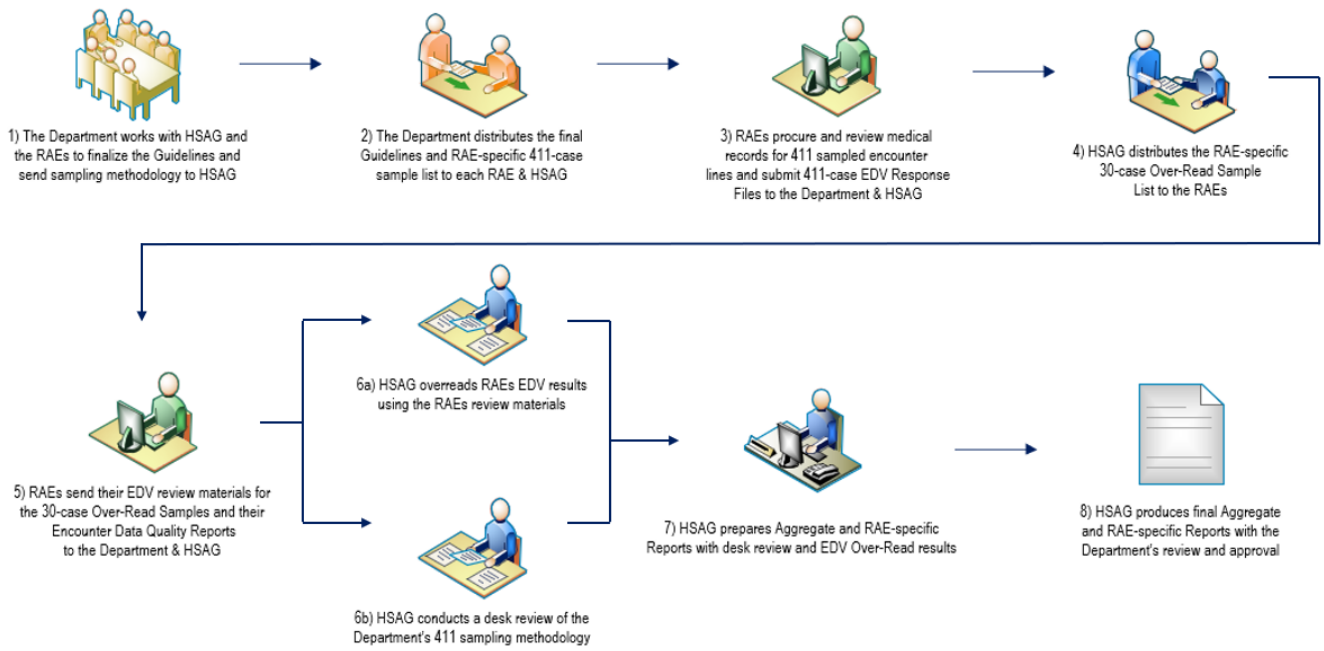
Encounter Data Validation—RAE 411 Audit Over-Read

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. Figure 2-2 diagrams the high-level steps involved in HSAG's 412 EDV over-read process, beginning in the upper left corner of the image.

[2-11] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2018. Available at: http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2013/10/2018-map.pdf. Accessed on: Oct 15, 2021.

Figure 2-2—FY 2020–2021 RAE 411 EDV Over-Read Process



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 411 final, paid encounter lines with dates of service between July 1, 2019, and June 30, 2020, from each RAE region's BH encounter flat file for each of the following BH service categories: Inpatient Services, Psychotherapy Services, and Residential Services. The RAEs reviewed medical records for the sampled 137 cases from each of the three service categories to evaluate the quality of the BH encounter data submitted to the Department.

HSAG reviewed the RAEs' internal audit documentation and over-read 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 Data Were Aggregated and Analyzed

HSAG compared each RAE's self-reported EDV results for each over-read case against the HSAG results to determine overall agreement with service coding accuracy. 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. Results were analyzed by service category and encounter data element to review trends within the agreement rates.

How Conclusions Were Drawn

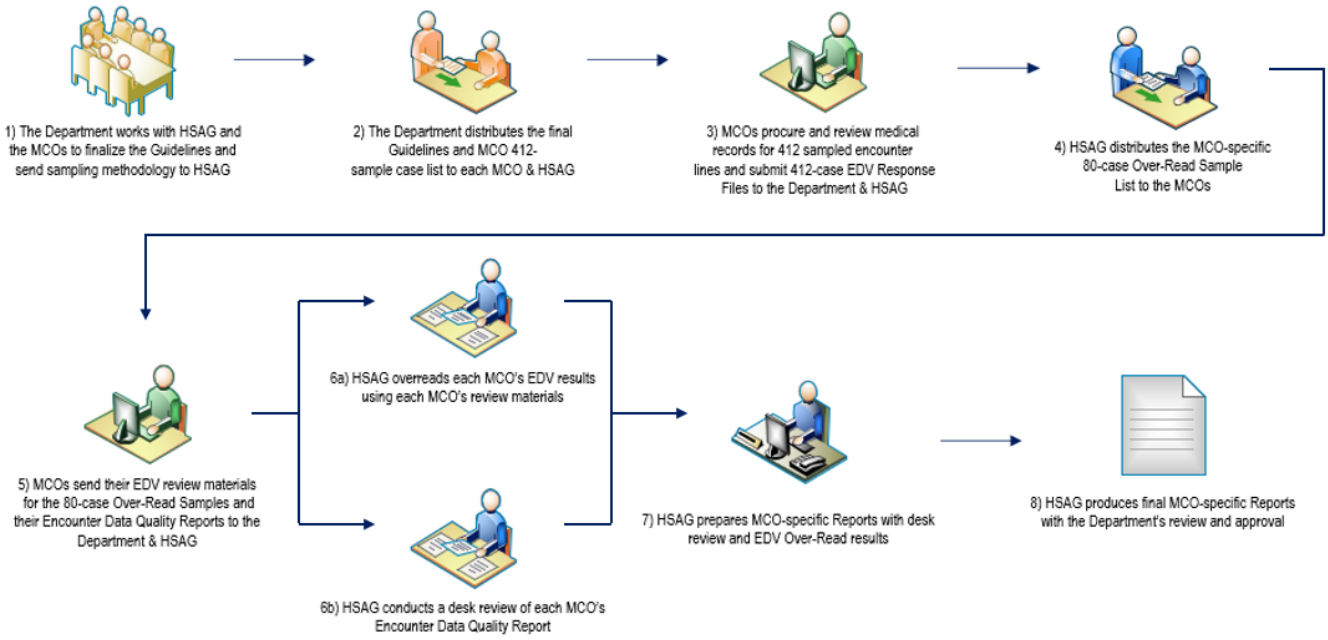
HSAG's over-read evaluated whether the RAEs' internal validation results were consistent with Colorado's Uniform Service Coding Standards (USCS) manuals and standard coding practices specific to the study period. Based on HSAG's level of agreement with each RAE's EDV results for the over-read cases, HSAG determined the extent to which the RAE's self-reported EDV results reflected encounter data quality.

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 used MRR to validate its encounter data. Figure 2-3 diagrams the high-level steps involved in HSAG's 412 EDV over-read process, beginning in the upper left corner of the image.

Figure 2-3—FY 2020–2021 MCO 412 EDV Over-Read Process



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 412 final, adjudicated encounter lines paid between October 1, 2019, and September 30, 2020, from each MCO's encounter data flat file the Department randomly sampled 103 cases 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 over-read 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 Data Were Aggregated and Analyzed

HSAG compared each MCO's self-reported EDV results for each over-read case against the HSAG results to determine overall agreement with service coding accuracy. 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. HSAG compiled each MCO's self-reported scores and compared against the HSAG over-read sample to determine overall agreement with service coding accuracy. Results were analyzed by service category and encounter data element to review trends within the agreement rates.

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. Based on HSAG's level of agreement with each MCO's EDV results for the over-read cases, HSAG determined the extent to which the MCO's self-reported EDV results reflected encounter data quality.

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. Adult members included as eligible for the survey were 18 years of age or older as of October 31, 2020. Child members included as eligible for the survey were 17 years of age or younger as of October 31, 2020. All sampled adult members and parents/caretakers of sampled child members completed the surveys from December 2020 to April 2021. The first phase consisted of an English or Spanish version of the cover letter being mailed to all sampled adult members and parents/caretakers of sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. The cover letters included a toll-free number that respondents could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a second reminder postcard. The second phase, or telephone phase, consisted of computer-assisted telephone interviewing (CATI) of parents/caretakers of sampled child members who had not mailed in a completed survey. A series of up to six CATI calls were made to each non-respondent at different times of the day, on different days of the week, and in different weeks.

The adult PCMH CAHPS survey included 35 items, and the child PCMH CAHPS survey included 47 items—all of which assess members' and parents'/caretakers' perspectives on healthcare services received from providers. 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

HSAG collected and aggregated the data attributed to the seven RAEs from survey respondents into a database for analysis. HSAG presents the FY 2020–2021 adult and child PCMH CAHPS top-box scores for the RAEs in the tables in Section 3.

For each global rating, the percentage of respondents who chose the top-box 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 or top-box 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 Data Were Aggregated and Analyzed

HSAG stratified the results by the seven RAEs. HSAG performed a trend analysis of the results in which the FY 2020–2021 scores were compared to their corresponding FY 2018–2019 scores to determine whether there were statistically significant differences.[2-12] Statistically significant differences between the FY 2020–2021 top-box scores and the FY 2018–2019 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in FY 2020–2021 than FY 2018–2019 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2020–2021 than FY 2018–2019 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG performed health plan comparisons of the results. Statistically significant differences between the RAEs' top-box responses and the Colorado RAE aggregate are noted with arrows. A RAE's

[2-12] The Department elected to survey the same practices from FY 2018–2019 for the FY 2020–2021 survey administration; therefore, the FY 2020–2021 scores are compared to the corresponding FY 2018–2019 scores.

top-box score that was statistically significantly higher than the Colorado RAE aggregate is noted with an upward green (↑) arrow. A RAE's top-box score that was statistically significantly lower than the Colorado RAE aggregate is noted with a downward red (↓) arrow. A RAE's top-box score that was not statistically significantly different than the Colorado RAE aggregate is not denoted with an arrow.

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 of the measures to one or more of these three domains. This assignment to domains is depicted in Table 2-11.

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

PCMH CAHPS 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 (Adult Only)	✓		✓

CAHPS Surveys—MCOs

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about patients' and parents'/caretakers' of child 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 5.1H Adult Medicaid Health Plan Survey* for the adult population and through the *CAHPS 5.1H Child Medicaid Health Plan Survey* 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 5.1H Adult Medicaid Health Plan Survey* and 41 items for the *CAHPS 5.1H Child Medicaid Health Plan Survey*) that assess respondents' 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.

The CAHPS surveys ask members and parents/caretakers 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 experience. These measures included four global ratings and four composite scores. The global ratings reflected members' and parents'/caretakers' overall experience with their/their child's 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 (+).

Description of Data Obtained

HSAG aggregated data from survey respondents into a database for analysis. Results of the CAHPS surveys for each Medicaid MCO are found in Section 3.

For each of the four global ratings, the percentage of respondents who chose the top-box 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 or top-box response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys were "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 5.1H Adult Medicaid Health Plan Survey* and *CAHPS 5.1H Child Medicaid Health Plan Survey* for DHMP and RMHP Prime. The health plans reported that NCQA methodology was followed in calculating these results.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the FY 2020–2021 scores were compared to their corresponding FY 2019–2020 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2020–2021 top-box scores and the FY 2019–2020 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in FY 2020–2021 than FY 2019–2020 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2020–2021 than FY 2019–2020 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG performed comparisons of the results to the NCQA national averages. Statistically significant differences between the MCOs' top-box responses and the NCQA national averages are noted with arrows. An MCO's top-box score that was statistically significantly higher than the NCQA national average is noted with an upward green (↑) arrow. An MCO's top-box score that was statistically significantly lower than the NCQA national average is noted with a downward red (↓) arrow. An MCO's top-box score that was not statistically significantly different than the NCQA national average is not denoted with an arrow.

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 measures to one or more of these three domains. This assignment to domains is depicted in Table 2-12.

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

CAHPS 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	✓		

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each EQR mandatory and optional activity conducted in FY 2020–2021. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

3. Evaluation of Colorado's Medicaid Managed Care Health Plans

Regional Accountable Entities

Region 1—Rocky Mountain Health Plans

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-1 and Table 3-2 display the FY 2020–2021 validation findings for RMHP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, RMHP completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, RMHP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that RMHP defined for the two PIP outcome measures in Module 1 are provided in Table 3-1.

Table 3-1—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE Members attributed to either SMFM or MFHC age 12 years or older, from 0.8% to 20%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of follow ups within 30 days of a positive depression screen among RAE Members attributed to either SMFM or MFHC age 12 years or older, from 0% to 46.89%.

In Module 2—Intervention Determination, RMHP conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, RMHP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by RMHP in Module 2 are summarized for the two PIP outcome measures in Table 3-2. The PIP had not progressed to the point of deploying and testing interventions. The interventions that RMHP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-2—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider compliance with standardized workflow for depression screening. • Provider awareness and understanding of appropriate depression screening coding practices.
Potential Interventions	• Implement provider and office staff education on depression screening workflow for office visits. • Incorporate accurate coding practices into standard depression screening workflow. • Produce provider education on appropriate depression screening coding and reporting practices.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Established workflow for patient follow-up care following a positive depression screen. • Referral and scheduling of follow-up visit in response to positive depression screen. • Appropriate billing practices for follow-up services.
Potential Interventions	• Establish processes and workflows to define appropriate care when a patient screens positive for depression. • Develop standardized workflow for follow-up service billing and integration of Current Procedural Terminology (CPT) codes. • Track members who screen positive for depression and are in need of follow-up behavioral services.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, RMHP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. RMHP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

RMHP: Strengths

The validation findings suggest that RMHP was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. RMHP also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential

interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As RMHP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- RMHP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as RMHP progresses through determining and testing interventions.
- RMHP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, RMHP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-3 shows the performance measure results for RMHP PMV FY 2018–2019 and FY 2019–2020.

Table 3-3—Performance Measure Results for RMHP

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	49.58%	41.72%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.15%	47.66%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	27.75%	30.85%	50.63%
Follow-Up After a Positive Depression Screen	44.87%	51.47%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.29%	13.57%	27.42%

RMHP: Strengths

For the PMV, 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. Additionally, RMHP improved its rates for three out of the five measures as compared to the previous year.

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

RMHP fell below the statewide average for four of the five measures being calculated. RMHP reported the lowest rates for *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)*. Additionally, RMHP fell below the Department's goal for all five measures. HSAG recommends that RMHP assess interventions that have been successful for similar indicators to determine if any intervention(s) and/or initiative(s) may be effective to improve rates and performance for each identified measure. Additionally, RMHP may want to consider creating a dashboard to view rates in real time and to create internal interim goals for each indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Overall Evaluation

Table 3-4 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 2020–2021.

Table 3-4—Summary of RMHP (Region 1) Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	15	1	0	0	94%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**67**	**2**	**0**	**0**	**97%***

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

Table 3-5 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 2020–2021.

Table 3-5—Summary of RMHP (Region 1) Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**166**	**166**	**0**	**24**	**100%****

**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 Credentialing and Recredentialing record review scores are based on a combined score for RMHP (Region 1) and RMHP Prime.*

RMHP: Strengths

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

RMHP maintained a well-established provider network that was sufficient to meet the needs of its members. Staff members described how the provider network is monitored and the process that occurs when gaps in the network are identified. RMHP achieved provider selection and continued provider participation in the network through numerous approaches, including by identifying service gaps, rewarding high performance providers through reimbursement strategies, and attending community events in which RMHP hosted informational sessions that outlined the contracting process. While in-person efforts were reduced due to the COVID-19 pandemic, RMHP continued efforts to contract providers to support the substance use disorder (SUD) expansion benefit in Grand County, which was heavily impacted by forest fires in FY 2020–2021. RMHP additionally described the various ways in which RMHP communicated and shared information with contracted providers, such as through the Program Improvement Advisory Committee (PIAC).

RMHP demonstrated a robust program integrity system through compliance program documents, which described appointment of the compliance officer, identified the compliance committee, and defined oversight of the program. The compliance committee provided oversight of compliance-related activities by reviewing risk assessments and assigning priorities based on compliance and/or business risks.

RMHP's credentialing and recredentialing process was clearly explained through procedures and followed NCQA credentialing standards. HSAG completed a review of initial and recredentialing sample files for individual providers; RMHP achieved 100 percent compliance with all record review elements.

Most delegated activities were related to credentialing and recredentialing; other delegated functions included pharmacy benefit management, behavioral health services, and utilization management (UM). RMHP maintained a comprehensive set of documents that reflected ongoing reporting and oversight activities, which included annual credentialing delegation audit reports. The department associated with the delegated function provided oversight, and monitoring activities were described in a delegation policy for each functional area.

RMHP maintained a well-developed, thorough, and continuous QAPI program as evidenced by the Annual Evaluation/Quality Assessment document, the Annual Evaluation Quality report, and the QI workplan. Documents contained informative summaries, data analysis, reflected successes and ongoing opportunities, identified and analyzed barriers, delineated councils and committee functions, and outlined the frequency of monitoring and review of data, performance metrics, and successes. Staff members described the status of one of RMHP's priority quality initiatives regarding the meaningful engagement of RAE stakeholders for RMHP's advisory councils, in which dashboards summarizing performance on key metrics were implemented and well-received by stakeholders and thus became a focal point in community and stakeholder meetings.

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

Although RMHP policies and procedures provided information regarding member liability for covered services, HSAG noted areas within the provider manual that did not contain entirely accurate information for specific lines of business (CHP+, RAE, and RMHP Prime). RMHP was required to revise the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities.

Some of the example credentialing delegation agreements did not include the required provisions regarding the right to audit by the HHS-OIG, Comptroller General, or other designees, and that records must be retained for up to 10 years. RMHP was required to update the delegated credentialing agreements to include all required language.

Validation of Network Adequacy

RMHP: Strengths

RMHP participated in all quarterly network adequacy reporting and the Department publishes RMHP's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While RMHP (Region 1) did not meet all minimum time and distance requirements across all counties in each county designation, RMHP's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, RMHP (Region 1) should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

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

Table 3-6—Self-Reported EDV Results by Data Element and BH Service Category for RMHP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	47.4%	91.2%
Principal Surgical Procedure Code	97.8%	NA	NA
Diagnosis Code	70.8%	30.7%	81.8%
Place of Service	NA	42.3%	91.2%
Service Category Modifier	NA	46.7%	91.2%
Units	NA	47.4%	91.2%
Revenue Code	74.5%	NA	NA
Discharge Status	94.9%	NA	NA
Service Start Date	90.5%	51.8%	91.2%
Service End Date	89.1%	51.8%	91.2%
Appropriate Population	NA	50.4%	91.2%
Duration	NA	46.7%	91.2%
Staff Requirement	NA	48.2%	91.2%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-7 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with RMHP's EDV results for each of the validated data elements.

Table 3-7—BH EDV Over-Read Agreement Results by BH Service Category for RMHP

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100%	90.0%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	90.0%	100%	90.0%
Place of Service	NA	100%	90.0%
Service Category Modifier	NA	100%	90.0%
Units	NA	100%	90.0%
Revenue Code	90.0%	NA	NA
Discharge Status	100%	NA	NA

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Service Start Date	90.0%	100%	90.0%
Service End Date	90.0%	100%	90.0%
Population	NA	100%	90.0%
Duration	NA	100%	90.0%
Staff Requirement	NA	90.0%	90.0%

NA indicates that a data element was not evaluated for the specified service category.

RMHP: Strengths

HSAG's over-read findings suggest a high level of confidence that RMHP's EDV results accurately reflect its encounter data quality. HSAG reviewers agreed with 100 percent of two of the six validated data elements within the inpatient services category and nine of the 10 validated data elements within the psychotherapy services category, although overall accuracy rates were under 52 percent. Overall, the residential services category had high self-reported accuracy and HSAG's reviewers agreed with 90 percent of the 10 over-read cases for all 10 validated data elements.

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

While over-read results suggest confidence in RMHP's self-reported EDV results, these EDV results demonstrated a low level of encounter data accuracy when compared to the corresponding medical records for psychotherapy services. As such, HSAG's EDV over-read results 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.

PCMH CAHPS Survey

RMHP: Adult PCMH CAHPS

Table 3-8 shows the adult PCMH CAHPS results for RMHP for FY 2018–2019 through FY 2020–2021.

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

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	66.8%	61.1%	72.4%	68.0%
Rating of Specialist Seen Most Often	63.9%	64.5%	65.8%	65.9%
Rating of All Health Care	60.2%	58.8%	68.1%	64.0%
Rating of Health Plan	58.2%	58.0%	65.4%	65.8%
Getting Timely Appointments, Care, and Information	48.3%	43.8%	53.1%	49.0%
How Well Providers Communicate with Patients	76.7%	74.9%	78.6%	76.2%
Providers' Use of Information to Coordinate Patient Care	66.4%	59.5%	66.3%	63.3%
Talking with You About Taking Care of Your Own Health	47.5%	48.7%	51.4%	50.3%
Comprehensiveness	55.7%	53.1%	55.8% ↑	53.5%
Helpful, Courteous, and Respectful Office Staff	71.8%	69.8%	74.4% ↑	69.2%
Health First Colorado Customer Service	65.5%	56.4%+	67.8%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	34.8%	32.6%+	37.5% ↑	25.9%
Reminders About Care from Provider Office	73.4%	70.3%	74.3%	73.3%
Saw Provider Within 15 Minutes of Appointment	43.5%	35.8%	44.4%	43.1%
Receive Health Care and Mental Health Care at Same Place	52.9%	56.0%	60.1%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, RMHP's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to RMHP's FY 2019–2020 results.

RMHP: Strengths

For the adult population, RMHP's scores for each measure were higher in FY 2020–2021 compared to FY 2019–2020. All but three scores were higher than the Colorado RAE aggregate score, with the scores being statistically significantly higher than the Colorado RAE aggregate on three measures: *Comprehensiveness*; *Helpful, Courteous, and Respectful Office Staff*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*.

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

For the adult population, HSAG found that three measures, although higher than when compared to the FY 2019–2020 rates, scored lower than the Colorado RAE aggregate score. These measures were *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, and *Receive Health Care and Mental Health Care at Same Place*, and were not statistically significantly lower than the aggregate rate. HSAG recommends that RMHP further explore perceptions regarding those measures and explore reasons the practices surveyed in FY 2020–2021 scored higher on most measures than practices surveyed in previous years and determine if any best practices can be shared with other practices in the region, and actions duplicated to improve scores.

RMHP: Child PCMH CAHPS

Table 3-9 shows the child PCMH CAHPS results for RMHP for FY 2018–2019 through FY 2020–2021.

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

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	75.1%	79.0%	76.6%	79.7%
Rating of Specialist Seen Most Often	67.0%+	74.3%+	73.7%+	70.3%
Rating of All Health Care	67.9%	78.8%	73.7%	79.2%
Getting Timely Appointments, Care, and Information	61.7%	70.3%	58.2%+ ↓	67.7%
How Well Providers Communicate with Child	77.7%	81.9%	68.0%+ ↓	80.0%
How Well Providers Communicate with Parents or Caretakers	81.0%	82.4%	77.2% ↓	83.5%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Providers' Use of Information to Coordinate Patient Care	71.1%	78.5%	72.7%	74.8%
Comprehensiveness—Child Development	61.7%	73.5%	63.7%	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	54.5%	66.1%	59.0%	61.8%
Helpful, Courteous, and Respectful Office Staff	67.1%	72.6%	65.6% ↓	69.6%
Received Information on Evening, Weekend, or Holiday Care	80.3%	82.9%	83.0%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	40.4%+	49.7%+	52.0%+	43.1%
Reminders About Child's Care from Provider Office	58.7%	74.5%	59.7% ↓	69.7%
Saw Provider Within 15 Minutes of Appointment	39.6%	40.8%	40.4% ↓	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, RMHP's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to RMHP's FY 2019–2020 results.

RMHP: Strengths

For the child population, HSAG found that three measures scored higher than the Colorado RAE aggregate score in FY 2020–2021 (*Rating of Specialist Seen Most Often*; *Received Information on Evening, Weekend, or Holiday Care*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*), although none were statistically significantly higher. Additionally, two of these scores were higher in FY 2020–2021 when compared to FY 2019–2020: *Received Information on Evening, Weekend, or Holiday Care*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*.

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

For the child population, HSAG found that RMHP scored lower than the Colorado RAE aggregate on all but two measures (see strengths above). On six of these measures, HSAG found the rates to be statistically significantly lower than the Colorado RAE aggregate: *Getting Timely Appointments, Care, and Information*; *How Well Providers Communicate with Child*; *How Well Providers Communicate with Parents or Caretakers*; *Helpful, Courteous, and Respectful Office Staff*; *Reminders About Child's Care from Provider Office*; and *Saw Provider Within 15 Minutes of Appointment*.

All of the six measures for which RMHP scored statistically significantly below the Colorado RAE aggregate score assess member perceptions related to quality of care. In addition, the *Getting Timely Appointments, Care, and Information* measure also assesses perceptions related to the timeliness and access domains, and the *Saw Provider Within 15 Minutes of Appointment* measure also assesses perceptions related to the timeliness domain. HSAG recommends that RMHP explore provider processes that may be contributing to low experience scores for these measures and develop initiatives designed to improve performance. Examples may include communications programs for providers or providing care reminders to encourage timely requests for services by the members. HSAG recommends that RMHP further explore perceptions regarding those measures. In addition, HSAG recommends that RMHP explore reasons the practices surveyed in FY 2020–2021 scored higher than practices surveyed in previous years and determine if any best practices can be shared with other practices and actions duplicated to improve scores.

Region 2—Northeast Health Partners

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-10 and Table 3-11 display the FY 2020–2021 validation findings for NHP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, NHP completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, NHP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that NHP defined for the two PIP outcome measures in Module 1 are provided in in Table 3-10.

Table 3-10—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC), ages 12 and up, from 84.04% to 85.06%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC ages 12 and up, from 40.22% to 47.66%.

In Module 2—Intervention Determination, NHP conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, NHP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by NHP in Module 2 are summarized for the two PIP outcome measures in Table 3-11. The PIP had not progressed to the point of deploying and testing interventions. The interventions that NHP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-11—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Documentation of depression screen in the EMR. • Screening completion.
Potential Interventions	• Provider education and engagement in accurate and complete depression screen EMR documentation.

Measure 1—*Depression Screening*	
	• Provider and staff feedback on depression screening metric performance. • Collaboration with provider on depression screening and reporting strategies.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Timely communication with behavioral health providers. • Closing behavioral health referral communication loop.
Potential Interventions	• Develop process flow for communicating positive depression screens to targeted behavioral health provider. • Develop process flow for referral loop communication between targeted primary care and behavioral health providers. • Capture behavioral health follow-up service on well visit claim for same-day services.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, NHP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. NHP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

NHP: Strengths

The validation findings suggest that NHP was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. NHP also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As NHP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- NHP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver

diagram should be updated regularly to incorporate knowledge gained and lessons learned as NHP progresses through determining and testing interventions.

- NHP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, NHP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-12 shows the performance measure results for NHP PMV FY 2018–2019 and FY 2019–2020.

Table 3-12—Performance Measure Results for NHP

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	46.40%	42.34%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	64.31%	74.23%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	38.33%	39.25%	50.63%
Follow-Up After a Positive Depression Screen	50.00%	53.25%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	15.76%	23.00%	27.42%

NHP: Strengths

For the PMV, 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 all five indicators. It reported the highest rate for *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)*.

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

NHP was above the statewide average for all five indicators. However, to continue to strive toward improvement, NHP 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 fiscal year.

Assessment of Compliance With Medicaid Managed Care Regulations

NHP Overall Evaluation

Table 3-13 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 2020–2021.

Table 3-13—Summary of NHP Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	15	1	0	0	94%
Standard VIII—Credentialing and Recredentialing	32	31	29	2	0	1	94%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Standard X—Quality Assessment and Performance Improvement	17	17	17	17	0	0	100%
Totals	**69**	**68**	**64**	**4**	**0**	**1**	**94%***

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

Table 3-14 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 2020–2021.

Table 3-14—Summary of NHP Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	50	40	40	0	10	100%
Recredentialing	45	35	35	0	10	100%
Totals	**95**	**75**	**75**	**0**	**20**	**100%***

**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 delegated provider recruiting, selection and retention activities, and day-to-day program integrity activities to Beacon Health Options (Beacon).The provider relations and network management activities were informed by regular data analysis of the provider network, claims, and utilization. NHP developed an annual network adequacy plan, which was cited as a key driver for ongoing activities such as recruitment and engagement; ongoing efforts were assessed through quarterly and monthly reporting. An ongoing focus within the frontier/rural service area included expanding and promoting telehealth services through distribution of member education and provider training regarding billing.

Policies and procedures included prevention, detection, investigation, and reporting/resolution functions for suspected fraud, waste, or abuse and conformed with federal and State regulations. The compliance team also engaged in ongoing educational activities such as annual conferences, obtaining certifications, and other topics specifically targeted to MCOs.

Policies submitted by NHP clearly outlined operational processes and procedures for evaluating initial and recredentialing applications, verifying required credentialing elements, applicant record approval, decision making to determine denial or disenrollment of network participation, and notification of determination. Review of the administrative records demonstrated NHP's timely primary source verification of licenses, education/training, work history, history of professional liability, State and Medicaid sanctions/exclusions, and practitioner applications/attestations.

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

The behavioral health and physical health provider manuals lacked details regarding whether NHP had any moral or religious objections to providing particular covered services. NHP was required to update informational materials to clarify that, while an individual provider may have such objections, NHP as an organization does not. Furthermore, HSAG recommended that NHP provide additional information stating that, if the provider objects to particular services, based on moral or religious grounds, the member should be referred back to NHP for assistance with identifying a different provider, if needed.

NHP's procedure for randomly sampling provider denials was conducted at a national level by Beacon and did not include a method to consistently ensure NHP providers were monitored. NHP was required to update policies, processes, and procedures to ensure representation of denied NHP practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination occurs.

NHP's policies and procedures did not describe a method for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NHP was required to implement a process to confirm that information remains accurate.

NHP's administrative service agreement included only some of the required provisions. NHP was required to update contracts and delegated agreements to include the complete detailed language specified in 42 CFR §438.230(c)(3).

Validation of Network Adequacy

NHP: Strengths

NHP participated in all quarterly network adequacy reporting and the Department publishes NHP's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While NHP did not meet all minimum time and distance requirements across all counties in each county designation, NHP's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

In general, the failure to meet the minimum network requirements was largely attributable to instances in which the closest network locations were outside the required standard, and the requirement that 100 percent of the RAE's members reside within the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, NHP should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-15 presents NHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.[3-1]

Table 3-15—Self-Reported EDV Results by Data Element and BH Service Category for NHP

Data Element	Inpatient Services (66 Cases)	Ambulatory Inpatient Services (71 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	98.6%	79.6%	100%
Principal Surgical Procedure Code	100%	NA	NA	NA
Diagnosis Code	98.5%	94.4%	82.5%	94.9%
Place of Service	NA	95.8%	75.2%	93.4%
Service Category Modifier	NA	98.6%	79.6%	100%
Units	NA	100%	81.8%	100%
Revenue codes	100%	NA	NA	NA
Discharge Status	100%	NA	NA	NA
Service Start Date	100%	100%	82.5%	100%
Service End Date	100%	100%	82.5%	100%
Population	NA	100%	82.5%	100%
Duration	NA	100%	82.5%	100%
Staff Requirement	NA	100%	82.5%	100%

NA indicates that a data element was not evaluated for the specified service category.

[3-1] After distributing the lists of sampled cases to the RAEs, a RAE notified the Department that selected Inpatient Services cases reflected services rendered in ambulatory settings, which would not align with the inpatient data fields designated for inclusion in the RAEs' EDV results. The Department instructed HSAG and NHP to consider sampled Inpatient Services cases with Place of Service codes other than "21" and "51" as professional services rendered in ambulatory settings, and to evaluate these cases using the non-inpatient data fields considered for the Psychotherapy Services and Residential Services cases. These cases are identified and reported in the EDV and HSAG's over-read as Ambulatory Inpatient Services cases and did not alter the overall number of NHP's sampled cases.

Table 3-16 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with NHP's EDV results for each of the validated data elements.

Table 3-16—BH EDV Over-Read Agreement Results by BH Service Category for NHP

Data Element	Inpatient Services (4 Over-Read Cases)	Ambulatory Inpatient Services (6 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	100%	100%	100%	100%
Principal Surgical Procedure Code	NA	NA	NA	NA
Diagnosis Code	100%	100%	100%	100%
Place of Service	NA	100%	100%	100%
Service Category Modifier	NA	16.7%	100%	100%
Units	NA	100%	100%	100%
Revenue Code	100%	NA	NA	NA
Discharge Status	0.0%	NA	NA	NA
Service Start Date	75.0%	100%	100%	100%
Service End Date	75.0%	100%	100%	100%
Population	NA	100%	100%	100%
Duration	NA	100%	100%	100%
Staff Requirement	NA	100%	100%	100%

NA indicates that a data element was not evaluated for the specified service category.

NHP: Strengths

NHP self-reported high overall accuracy for the inpatient services, ambulatory inpatient services, and residential services categories (i.e., at or above 90 percent accuracy), and HSAG's over-read findings suggest a high level of confidence that NHP's EDV results accurately reflect its encounter data quality. HSAG's over-read results agreed with 100 percent of three of the six encounter data types for inpatient services scores, nine of the 10 elements for ambulatory inpatient services, and all 10 elements for psychotherapy and residential services, although results for psychotherapy services cases were moderately accurate (i.e., approximately 80 percent).

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

While over-read results suggest confidence in NHP's EDV results, some of NHP's self-reported EDV results themselves demonstrated a low level of encounter data accuracy. At 0.0 percent, the *Discharge Status* data element had the lowest rate of agreement between NHP's EDV results and HSAG's over-

read results. Additionally, HSAG reported only 16.7 percent agreement for the *Service Category Modifier* data element within the ambulatory inpatient services category.

NHP's self-reported EDV results demonstrate a low level of encounter data accuracy when compared to the corresponding medical records for psychotherapy services. As such, over-read results 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.

PCMH CAHPS Survey

NHP: Adult PCMH CAHPS

Table 3-17 shows the adult PCMH CAHPS results for NHP for FY 2018–2019 through FY 2020–2021.

Table 3-17—Adult PCMH CAHPS Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	72.1%	67.0%	75.3% ↑	68.0%
Rating of Specialist Seen Most Often	69.7%	57.9%	73.0%	65.9%
Rating of All Health Care	64.3%	61.2%	71.1% ↑	64.0%
Rating of Health Plan	64.4%	63.7%	72.5%	65.8%
Getting Timely Appointments, Care, and Information	58.8%	52.0%	57.5% ↑	49.0%
How Well Providers Communicate with Patients	79.2%	77.9%	78.4%	76.2%
Providers' Use of Information to Coordinate Patient Care	67.0%	66.9%	65.1%	63.3%
Talking with You About Taking Care of Your Own Health	47.1%	49.7%	47.5%	50.3%
Comprehensiveness	54.9%	50.9%	50.7%	53.5%
Helpful, Courteous, and Respectful Office Staff	74.3%	66.7%	75.4% ↑	69.2%
Health First Colorado Customer Service	59.7%+	57.0%+	65.0%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	24.7%+	31.9%+	33.0%+	25.9%
Reminders About Care from Provider Office	63.1%	67.2%	69.0%	73.3%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Saw Provider Within 15 Minutes of Appointment	52.7%	45.2%	55.1% ↑	43.1%
Receive Health Care and Mental Health Care at Same Place	54.5%	63.5%	65.5%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, NHP's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to NHP's FY 2019–2020 results.

NHP: Strengths

For the adult population, NHP's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except for three: *Providers' Use of Information to Coordinate Patient Care*, *Talking with You About Taking Care of Your Own Health*, and *Comprehensiveness*. In addition, NHP scored higher than the Colorado RAE aggregate score in all measures except three (see opportunities for improvement below) and scored statistically significantly higher than the Colorado RAE aggregate on five measures: *Rating of Provider*; *Rating of All Health Care*; *Getting Timely Appointments, Care, and Information*; *Helpful, Courteous, and Respectful Office Staff*; and *Saw Provider Within 15 Minutes of Appointment*.

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

For the adult population, HSAG found that three measures scored lower than the Colorado RAE aggregate score (*Talking with You About Taking Care of Your Own Health*, *Comprehensiveness*, and *Reminders About Care from Provider Office*), although none were statistically significantly lower. These three measures are most closely associated with the quality domain. HSAG recommends that NHP further explore factors that drive member perceptions regarding those measures. Potential initiatives to improve member perceptions of quality may be provider training or messaging about communication skills or practice guidelines, or collaborating with the provider offices to develop care reminders.

NHP: Child PCMH CAHPS

Table 3-18 shows the child PCMH CAHPS results for NHP for FY 2018–2019 through FY 2020–2021.

Table 3-18—Child PCMH CAHPS Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	83.3%	80.5%	68.0%+ ↓	79.7%
Rating of Specialist Seen Most Often	76.4%+	84.3%+	82.1%+	70.3%
Rating of All Health Care	75.8%	76.7%	72.3%+	79.2%
Getting Timely Appointments, Care, and Information	73.7%+	57.9%+	66.7%+	67.7%
How Well Providers Communicate with Child	79.0%+	82.7%+	75.4%+	80.0%
How Well Providers Communicate with Parents or Caretakers	84.1%	78.2%	75.0%+ ↓	83.5%
Providers' Use of Information to Coordinate Patient Care	80.0%+	69.8%	65.3%+	74.8%
Comprehensiveness—Child Development	68.3%	64.9%	64.8%+	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	59.3%	60.8%	56.2%+	61.8%
Helpful, Courteous, and Respectful Office Staff	70.3%	63.6%	71.7%+	69.6%
Received Information on Evening, Weekend, or Holiday Care	70.1%	76.4%	76.0%+	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	20.9%+	9.1%+	32.9%+	43.1%
Reminders About Child's Care from Provider Office	54.7%	61.3%	59.6%+	69.7%
Saw Provider Within 15 Minutes of Appointment	48.1%	37.6%	49.2%+	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, NHP's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to NHP's FY 2019–2020 results.

NHP: Strengths

For the child population, HSAG found that three measures scored higher than the Colorado RAE aggregate score in FY 2020–2021 (*Rating of Specialist Seen Most Often*; *Helpful, Courteous, and Respectful Office Staff*; and *Saw Provider Within 15 Minutes of Appointment*), although none were statistically significantly higher. Additionally, NHP's scores were higher in FY 2020–2021 compared to FY 2019–2020 for four measures: *Getting Timely Appointments, Care, and Information*; *Helpful, Courteous, and Respectful Office Staff*; *Received Care from Provider Office During Evenings, Weekends, or Holidays*; and *Saw Provider Within 15 Minutes of Appointment*. Although remaining below the Colorado RAE aggregate score for the measure, the most notable improvement was the *Received Care from Provider Office During Evenings, Weekends, or Holiday* rate; the NHP rate was 9.1 percent for the provider practices surveyed in FY 2019–2020 and 32.9 percent for the provider practices surveyed in FY 2020–2021.

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

For the child population, NHP scored lower than the Colorado RAE aggregate score on all but three measures and statistically significantly lower than the Colorado RAE aggregate on two measures: *Rating of Provider* and *How Well Providers Communicate with Parents or Caretakers*.

HSAG recommends that NHP explore barriers that may be contributing to low experience scores for these two measures. These measures are directly related to the quality of care domain. HSAG recommends NHP develop initiatives to look more closely at factors that drive member perceptions of quality. Potential initiatives may be training or messaging to providers regarding communication skills. HSAG also recommend that NHP explore best practices at provider offices surveyed in FY 2020–2021 related to the *Received Care from Provider Office During Evenings, Weekends, or Holiday* rate to determine if process may be duplicated in additional provider offices.

Region 3—Colorado Access

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-19 and Table 3-20 display the FY 2020–2021 validation findings for COA Region 3's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, COA Region 3 completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, COA Region 3 defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that COA Region 3 defined for the two PIP outcome measures in Module 1 are provided in Table 3-19.

Table 3-19—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 and older who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 86.84% to 88.72%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 and older within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 56.81% to 65.76%.

In Module 2—Intervention Determination, COA Region 3 conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, COA Region 3 updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by COA Region 3 in Module 2 are summarized for the two PIP outcome measures in Table 3-20. The PIP had not progressed to the point of deploying and testing interventions. The interventions that COA Region 3 ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-20—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider standards of care and coding consistency. • Depression screening occurs at every well visit. • Member engagement and education. • Appointment availability and access.

Measure 1—*Depression Screening*	
Potential Interventions	• Standardization of depression screen scoring. • Provider education on appropriate coding practices. • Promotion of telehealth options for well visits. • Standardization of sick visit screening protocols. • Optimization of EHR to support ordering and properly coding depression screens. • Automated well visit scheduling and reminder outreach. • Member education on appointment access and availability services.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider standards of care for behavioral health referral process. • Provider education on appropriate behavioral health follow-up coding practices. • Internal and external provider availability for behavioral health follow-up visits. • Member access, knowledge, and engagement.
Potential Interventions	• Targeted provider education on effective referral processes. • Provider workflow improvement and standardization. • Provider education on appropriate coding practices. • Expand telehealth follow-up options through COA's free Virtual Care Collaboration and Integration (VCCI) program. • Develop member resources for behavioral health and referral resources.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, COA Region 3 will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. COA Region 3 will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

COA Region 3: Strengths

The validation findings suggest that COA Region 3 was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. COA Region 3 also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential

interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As COA Region 3 continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- COA Region 3 should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as COA Region 3 progresses through determining and testing interventions.
- COA Region 3 should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, COA Region 3 should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-21 shows the performance measure results for COA Region 3 PMV FY 2018–2019 and FY 2019–2020.

Table 3-21—Performance Measure Results for COA Region 3

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.75%	38.84%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.76%	64.71%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	27.83%	31.97%	50.63%
Follow-Up After a Positive Depression Screen	43.51%	41.50%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	12.05%	12.17%	27.42%

COA Region 3: Strengths

For the PMV, COA Region 3 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 Region 3 was above at the statewide average for *Engagement in Outpatient Substance Use Disorder (SUD) Treatment*.

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

COA Region 3 fell below the statewide average for four out of the five indicators. It reported the lowest rate for *Behavioral Health Screening or Assessment for Children in the Foster Care System*. HSAG recommends that COA Region 3 assess interventions that have been successful for similar indicators to determine if any intervention(s) and/or initiative(s) may be effective to improve rates and performance for each identified measure. Additionally, COA Region 3 may want to consider creating a dashboard to view rates in real time and to create internal interim goals for each indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 3 Overall Evaluation

Table 3-22 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2020–2021.

Table 3-22—Summary of COA Region 3 Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	16	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**69**	**0**	**0**	**0**	**100%***

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

Table 3-23 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 2020–2021.

Table 3-23—Summary of COA Region 3 Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	84	84	0	16	100%
Recredentialing	90	77	77	0	13	100%
Totals	**190**	**161**	**161**	**0**	**29**	**100%****

**COA Credentialing record review scores are based on a combined score for COA Region 3 and COA Region 5.*

***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

Efforts to retain quality providers included provider newsletters, support from provider relations staff members, and occasional webinars/calls for idea sharing. Staff members described plans to improve assessment of new providers and monitoring of the existing network in 2021, using the expansion of Colorado's SUD benefit to launch this new approach. Compliance policies and procedures included thorough details about training content, and compliance staff members developed numerous tailored trainings, which were deployed in various departments. Clear and effective lines of communication and expectations for prompt reporting were evident in the submitted materials as well as comprehensive information about fraud, waste, and abuse. COA Region 3 operated a three-tiered Compliance Committee structure, which included the management level, the executive team, and up to the board of directors for wide-ranging oversight.

COA Region 3's credentialing and provider data department demonstrated extensive policies and procedures for credentialing and recredentialing providers. These procedures followed NCQA credentialing and recredentialing standards and demonstrated a uniform approach to assess provider applications. Documentation demonstrated thorough review criteria, sources for verification, and file management steps to ensure accurate and timely credentialing decisions were made. A review of credentialing, recredentialing, and organizational credentialing records demonstrated 100 percent compliance with timely initial and ongoing reviews, which included all key criteria within verification time limits.

HSAG reviewed a sample of selected delegation agreements, and found that each outlined the delegated activities, indicated that the contractor agreed to perform the delegated activities, and included provisions for COA Region 3 to take action, including revocation, if the contracted entity failed to meet its obligations. In the agreements reviewed, COA Region 3 included language that the delegated entity was required to adhere to CMS requirements and State laws, retain records for 10 years, and allow for an audit upon the request of COA Region 3 or any regulatory body. In the event that a delegate did not

meet required standards, COA Region 3 maintained policies and procedures to enact corrective action plans (CAPs).

COA Region 3's QAPI Program Description and Annual Quality Report described a comprehensive QAPI program that outlined mechanisms to address care appropriateness, safety, quality, and member experience. Staff members reported that health information data were collected and managed through multiple systems and configured through COA Region 3's enterprise data warehouse. COA Region 3 described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance, and identify cost and care trends for use across the organization.

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

HSAG identified no areas for opportunity that lead to required actions for the four standards reviewed in FY 2020–2021.

Validation of Network Adequacy

COA Region 3: Strengths

COA Region 3 participated in all quarterly network adequacy reporting and the Department publishes COA Region 3's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While COA Region 3 did not meet all minimum time and distance requirements across all counties in each county designation, COA Region 3's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, COA Region 3 should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-24 presents COA Region 3's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-24—Self-Reported EDV Results by Data Element and BH Service Category for COA Region 3

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	53.2%	75.9%
Principal Surgical Procedure Code	94.9%	NA	NA
Diagnosis Code	89.1%	85.4%	93.4%
Place of Service	NA	75.9%	82.5%
Service Category Modifier	NA	53.2%	75.9%
Units	NA	94.9%	94.9%
Revenue Code	100%	NA	NA
Discharge Status	100%	NA	NA
Service Start Date	100%	95.6%	95.6%
Service End Date	100%	95.6%	95.6%
Population	NA	95.6%	95.6%
Duration	NA	85.4%	94.9%
Staff Requirement	NA	92.7%	92.7%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-25 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with COA Region 3's EDV results for each of the validated data elements.

Table 3-25—BH EDV Over-Read Agreement Results by BH Service Category for COA Region 3

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	90.0%	80.0%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	100%	100%	90.0%
Place of Service	NA	100%	100%
Service Category Modifier	NA	100%	NA
Units	NA	100%	100%
Revenue Code	90.0%	NA	NA
Discharge Status	100%	NA	NA
Service Start Date	100%	100%	100%
Service End Date	100%	100%	100%
Population	NA	100%	100%
Duration	NA	90.0%	100%
Staff Requirement	NA	100%	100%

NA indicates that a data element was not evaluated for the specified service category.

COA Region 3: Strengths

COA Region 3 self-reported generally high service coding accuracy for inpatient services and residential services cases, with lower accuracy scores for psychotherapy services. Additionally, HSAG's over-read findings suggest a high level of confidence that COA Region 3's EDV results accurately reflect its encounter data quality. HSAG reported 100 percent agreement with five of the six inpatient services data elements, eight of the 10 psychotherapy services data elements, and seven of the 10 residential services data elements.

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

COA Region 3's self-reported EDV results demonstrated only a moderate level of accuracy within the psychotherapy services category, including 53.2 percent accuracy for the *Service Category Modifier* element. As such, COA Region 3 may consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

PCMH CAHPS Survey

COA Region 3: Adult PCMH CAHPS

Table 3-26 shows the adult PCMH CAHPS results for COA Region 3 for FY 2018–2019 through FY 2020–2021.

Table 3-26—Adult PCMH CAHPS Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	62.5%	56.6%	71.3%	68.0%
Rating of Specialist Seen Most Often	68.6%	65.0%	69.3%	65.9%
Rating of All Health Care	59.8%	55.0%	66.3%	64.0%
Rating of Health Plan	61.5%	61.3%	66.4%	65.8%
Getting Timely Appointments, Care, and Information	44.9%	45.7%	46.0% ↓	49.0%
How Well Providers Communicate with Patients	73.4%	69.0%	75.9%	76.2%
Providers' Use of Information to Coordinate Patient Care	62.6%	57.6%	64.7%	63.3%
Talking with You About Taking Care of Your Own Health	49.8%	46.9%	49.8%	50.3%
Comprehensiveness	54.4%	53.6%	53.5%	53.5%
Helpful, Courteous, and Respectful Office Staff	64.9%	60.4%	68.8%	69.2%
Health First Colorado Customer Service	61.8%	59.7%	61.5%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.8%	26.7%+	24.2%	25.9%
Reminders About Care from Provider Office	70.7%	70.7%	74.2%	73.3%
Saw Provider Within 15 Minutes of Appointment	40.9%	38.8%	41.9%	43.1%
Receive Health Care and Mental Health Care at Same Place	58.0%	52.5%	63.4%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, COA Region 3's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to COA Region 3's FY 2019–2020 results.

COA Region 3: Strengths

For the adult population, HSAG found that seven measures scored higher than the Colorado RAE aggregate score in FY 2020–2021, although none were statistically significantly higher:

- *Rating of Provider*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*
- *Providers' Use of Information to Coordinate Patient Care*
- *Reminders About Care from Provider Office*
- *Receive Health Care and Mental Health Care at Same Place*

Additionally, COA Region 3's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except two: *Comprehensiveness* and *Received Care from Provider Office During Evenings, Weekends, or Holidays*.

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

For the adult population, HSAG found that seven measures scored lower than the Colorado RAE aggregate score and one measure scored statistically significantly lower; *Getting Timely Appointments, Care, and Information*. HSAG recommends that COA Region 3 further explore perceptions that may be contributing to low experience scores for this measure. In addition, HSAG recommends that COA Region 3 explore reasons the practices surveyed in FY 2020–2021 scored higher than practices surveyed in previous years on nearly all measures and determine if any best practices can be shared with other practices in the region and actions duplicated to improve scores.

COA Region 3: Child PCMH CAHPS

Table 3-27 shows the child PCMH CAHPS results for COA Region 3 for FY 2018–2019 through FY 2020–2021.

Table 3-27—Child PCMH CAHPS Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	74.9%	71.2%	79.7%	79.7%
Rating of Specialist Seen Most Often	77.2%	75.3%	71.4%	70.3%
Rating of All Health Care	74.1%	73.1%	80.3%	79.2%
Getting Timely Appointments, Care, and Information	68.4%	48.4%	67.0%	67.7%
How Well Providers Communicate with Child	80.0%	78.5%	80.6%	80.0%
How Well Providers Communicate with Parents or Caretakers	81.7%	78.1%	84.4%	83.5%
Providers' Use of Information to Coordinate Patient Care	73.9%	69.4%	75.9%	74.8%
Comprehensiveness—Child Development	66.8%	70.4%	70.1%	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	59.6%	68.3%	64.2% ↑	61.8%
Helpful, Courteous, and Respectful Office Staff	66.2%	59.4%	67.0% ↓	69.6%
Received Information on Evening, Weekend, or Holiday Care	80.9%	80.4%	81.4%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	25.9%+	25.4%	44.8%+	43.1%
Reminders About Child's Care from Provider Office	69.1%	72.2%	75.5% ↑	69.7%
Saw Provider Within 15 Minutes of Appointment	41.4%	31.5%	44.1% ↓	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, COA Region 3's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to COA Region 3's FY 2019–2020 results.

COA Region 3: Strengths

For the child population, COA Region 3's scores for were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except three: *Rating of Specialist Seen Most Often*, *Comprehensiveness—Child Development*, and *Comprehensiveness—Child Safety and Healthy Lifestyles*. In addition, COA Region 3 scored statistically significantly higher than the Colorado RAE aggregate on two measures: *Comprehensiveness—Child Safety and Healthy Lifestyles* and *Reminders About Child's Care from Provider Office*.

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 on two measures: *Helpful, Courteous, and Respectful Office Staff* and *Saw Provider Within 15 Minutes of Appointment*. Also, COA Region 3's FY 2020–2021 scores for two additional measures were lower than the Colorado RAE aggregate: *Getting Timely Appointments, Care, and Information* and *Received Information on Evening, Weekend, or Holiday Care*, although not statistically significantly. While each of these scores are below the aggregate rate, it should be noted that they were above the rates reported for each of these measures in FY 2019–2020. HSAG recommends that COA Region 3 explore reasons the practices surveyed in FY 2020–2021 scored higher than practices surveyed in previous years on the same measures and determine if any best practices can be shared with other practices and actions duplicated to improve scores.

Region 4—Health Colorado, Inc.

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-28 and Table 3-29 display the FY 2020–2021 validation findings for HCI's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, HCI completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, HCI defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that HCI defined for the two PIP outcome measures in Module 1 are provided in Table 3-28.

Table 3-28—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older, from 11.21% to 15%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from 25.15% to 30%.

In Module 2—Intervention Determination, HCI conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, HCI updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by HCI in Module 2 are summarized for the two PIP outcome measures in Table 3-29. The PIP had not progressed to the point of deploying and testing interventions. The interventions that HCI ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-29—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Primary care provider education, knowledge, and awareness of depression screening impact. • EMR capability to incorporate scanned depression screening forms. • Data accuracy.

Measure 1—*Depression Screening*	
Potential Interventions	• Identify provider billing and reporting strategies to support depression screening documentation in EMR. • Implement provider townhalls and/or learning collaboratives to discuss depression screening services and reduce stigma. • Ensure provider understanding and use of correct depression screening codes. • Staff training and feedback on depression screening metric performance.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• PCP collaboration to coordinate depression screening and follow-up services. • Timely communication with behavioral health provider following positive depression screen in primary care setting. • Ensure follow-up services area billed when provided on the same day as the positive depression screen.
Potential Interventions	• Case managers and care coordinators work with primary care offices to verify follow-up services are provided for positive depression screens. • Coordinate depression screening and follow-up services at primary care offices by case managers or care coordinators. • Capture behavioral health follow-up services on well visit claim when follow-up services are provided on the same day as the positive depression screen.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, HCI will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. HCI will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

HCI: Strengths

The validation findings suggest that HCI was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. HCI also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As HCI continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- HCI should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as HCI progresses through determining and testing interventions.
- HCI should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, HCI should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-30 shows the performance measure results for HCI PMV FY 2018–2019 and FY 2019–2020.

Table 3-30—Performance Measure Results for HCI

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.93%	31.19%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	74.36%	71.20%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	46.03%	37.58%	50.63%
Follow-Up After a Positive Depression Screen	42.98%	34.64%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	24.93%	23.70%	27.42%

HCI: Strengths

For the PMV, 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. HCI reported the highest rates for *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*.

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

HCI fell below the statewide average for *Follow-Up After a Positive Depression Screen*. HSAG recommends that HCI assess interventions that have been successful for similar indicators to determine if any intervention(s) and/or initiative(s) may be effective to improve rates and performance for each identified measure. Additionally, HCI may want to consider creating a dashboard to view rates in real time and to create internal interim goals for each indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

HCI Overall Evaluation

Table 3-31 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 2020–2021.

Table 3-31—Summary of HCI Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	15	1	0	0	94%
Standard VIII—Credentialing and Recredentialing	32	31	29	2	0	1	94%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**68**	**64**	**4**	**0**	**1**	**94%***

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

Table 3-32 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 2020–2021.

Table 3-32—Summary of HCI Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	50	40	40	0	10	100%
Recredentialing	45	35	35	0	10	100%
Totals	**95**	**75**	**75**	**0**	**20**	**100%***

**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 delegated provider recruiting, selection and retention activities, and day-to-day program integrity activities to Beacon. HCI submitted comprehensive policies, procedures, supporting sample reports, and other documents that demonstrated alignment with State and federal requirements related to provider participation and program integrity. The provider relations and network management activities were informed through regularly scheduled analysis of the provider network, claims, and utilization data. SUD providers were a major focus of recruitment throughout 2020 in preparation for the SUD benefit expansion. Additionally, HCI leveraged self-service tools, trainings, and roundtable meetings to retain providers. The roundtables provided a venue through which providers could interact with HCI and also engage with each other to learn about best practices. HCI's program integrity monitoring included reports on member prescriptions, card sharing instances, general claim oversight, overpayments (upcoding, unbundling, services not rendered, inflated billing, improper payments), and other compliance risks as identified.

HCI's established policies, procedures, and supporting documents demonstrated adequate systems to ensure that all credentialing and recredentialing processes meet NCQA, federal, and State specifications and requirements.

All HCI quality functions were delegated to Beacon. HCI's Quality Improvement Plan and annual Quality Report described a comprehensive quality assurance and performance improvement (QAPI) program that included strategies aimed to improve the health of the region's members. The Beacon Data Flow document demonstrated the HCI workflow used for collection, analysis, integration, and reporting of data from internal and external sources.

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

The behavioral health and physical health provider manuals lacked details regarding if HCI had any moral or religious objections to providing particular covered services. HCI was required to update informational materials to clarify that, while an individual provider may have such objections, HCI as an organization does not. Furthermore, HSAG recommended that HCI provide additional information stating that, if the provider objects to particular services, based on moral or religious grounds, the member should be referred back to HCI to assist with identifying a different provider, if needed.

HCI's procedure for randomly sampling provider denials was conducted at a national level by Beacon and did not include a method to consistently ensure HCI providers were monitored. HCI was required to update policies, processes, and procedures to ensure representation of denied HCI practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination occurs.

HCI's policies and procedures did not describe a method for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. HCI was required to implement a process to confirm accurate information.

HCI's administrative service agreement included only some of the required provisions. HCI was required to update contracts and delegated agreements to include the complete detailed language specified in 42 CFR §438.230(c)(3).

Validation of Network Adequacy

HCI: Strengths

HCI participated in all quarterly network adequacy reporting and the Department publishes HCI's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While HCI did not meet all minimum time and distance requirements across all counties in each county designation, HCI's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, HCI should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-33 presents HCI's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-33—Self-Reported EDV Results by Data Element and BH Service Category for HCI

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	94.9%	99.3%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	98.5%	94.2%	98.5%
Place of Service	NA	94.2%	99.3%
Service Category Modifier	NA	94.9%	99.3%
Units	NA	99.3%	99.3%
Revenue Code	100%	NA	NA
Discharge Status	99.3%	NA	NA
Service Start Date	100%	99.3%	99.3%
Service End Date	100%	99.3%	99.3%
Population	NA	99.3%	99.3%
Duration	NA	99.3%	99.3%
Staff Requirement	NA	98.5%	99.3%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-34 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with HCI's EDV results for each of the validated data elements.

Table 3-34—BH EDV Over-Read Agreement Results by BH Service Category for HCI

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100%	100%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	100%	90.0%	100%
Plan of Service	NA	100%	100%
Service Category Modifier	NA	100%	100%
Units	NA	100%	100%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Revenue Code	100%	NA	NA
Discharge Status	10.0%	NA	NA
Service Start Date	100%	100%	100%
Service End Date	100%	100%	100%
Population	NA	100%	100%
Duration	NA	100%	100%
Staff Requirement	NA	100%	100%

NA indicates that a data element was not evaluated for the specified service category.

HCI: Strengths

HCI reported high overall service coding accuracy for all three service categories and HSAG's over-read findings suggest a high level of confidence that HCI's EDV results accurately reflect its encounter data quality. HSAG was in 100 percent agreement with five of the six data elements within inpatient services, nine of the 10 data elements within psychotherapy services, and all 10 data elements within residential services.

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

While over-read results suggest confidence in HCI's EDV results, some of HCI's self-reported EDV results themselves demonstrated a low level of encounter data accuracy. HSAG identified an opportunity for HCI to review criteria for documenting a patient's discharge status within inpatient services and recommends additional internal staff and provider training and ongoing encounter data monitoring and assurance of accuracy.

PCMH CAHPS Survey

HCI: Adult PCMH CAHPS

Table 3-35 shows the adult PCMH CAHPS results for HCI for FY 2018–2019 through FY 2020–2021.

Table 3-35—Adult PCMH CAHPS Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	63.3%	68.5%	66.4%	68.0%
Rating of Specialist Seen Most Often	62.6%	61.4%	68.9%	65.9%
Rating of All Health Care	61.0%	61.5%	61.7%	64.0%
Rating of Health Plan	60.5%	66.6%	65.5%	65.8%
Getting Timely Appointments, Care, and Information	51.9%	56.8%	59.9% ↑	49.0%
How Well Providers Communicate with Patients	75.0%	76.4%	80.0%	76.2%
Providers' Use of Information to Coordinate Patient Care	61.1%	66.0%	62.5%	63.3%
Talking with You About Taking Care of Your Own Health	44.6%	51.8%	50.6%	50.3%
Comprehensiveness	43.2%	49.3%	46.9% ↓	53.5%
Helpful, Courteous, and Respectful Office Staff	72.3%	69.5%	73.4%	69.2%
Health First Colorado Customer Service	66.9%	62.1%	64.1%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	38.5%+	34.1%	35.9%+	25.9%
Reminders About Care from Provider Office	73.0%	71.5%	72.0%	73.3%
Saw Provider Within 15 Minutes of Appointment	35.9%	38.1%	43.3%	43.1%
Receive Health Care and Mental Health Care at Same Place	57.8%	52.4%	60.1%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, HCI's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to HCI's FY 2019–2020 results.

HCI: Strengths

For the adult population, HCI's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except five: *Rating of Provider*, *Rating of Health Plan*, *Providers' Use of Information to Coordinate Patient Care*, *Talking with You About Taking Care of Your Own Health*, and *Comprehensiveness*. In addition, HCI scored higher than the Colorado RAE aggregate score on eight measures:

- *Rating of Specialist Seen Most Often*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Patients*
- *Talking with You About Taking Care of Your Own Health*
- *Helpful, Courteous, and Respectful Office Staff*
- *Health First Colorado Customer Service*
- *Received Care from Provider Office During Evenings, Weekends, or Holidays*
- *Saw Provider Within 15 Minutes of Appointment*

For one measure, HCI's score was statistically significantly higher; *Getting Timely Appointments, Care, and Information*.

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

For the adult population, HCI scored lower than the Colorado RAE aggregate for six measures:

- *Rating of Provider*
- *Rating of All Health Care*
- *Rating of Health Plan*
- *Providers' Use of Information to Coordinate Patient Care*
- *Reminders About Care from Provider Office*
- *Receive Health Care and Mental Health Care at Same Place*

For one measure, HCI's score was statistically significantly lower (*Comprehensiveness*). These scores are primarily related to the quality of care domain. HSAG recommends that HCI explore factors that may be contributing to member perceptions of quality and the low experience scores, particularly *Comprehensiveness*, and develop quality initiatives designed to improve member perceptions of quality of care. Examples may include trainings or messaging to providers on communication skills.

HCI: Child PCMH CAHPS

Table 3-36 shows the child PCMH CAHPS results for HCI for FY 2018–2019 through FY 2020–2021.

Table 3-36—Child PCMH CAHPS Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	65.3%	65.1%	73.5%	79.7%
Rating of Specialist Seen Most Often	69.5%+	73.6%+	60.3%+	70.3%
Rating of All Health Care	69.9%	62.7%	73.5%	79.2%
Getting Timely Appointments, Care, and Information	60.6%	56.8%	60.1% ↓	67.7%
How Well Providers Communicate with Child	78.1%	75.3%	75.5%	80.0%
How Well Providers Communicate with Parents or Caretakers	78.1%	75.8%	79.8%	83.5%
Providers' Use of Information to Coordinate Patient Care	72.3%	69.6%	74.0%	74.8%
Comprehensiveness—Child Development	56.8%	51.6%	57.5% ↓	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	49.0%	49.0%	48.3% ↓	61.8%
Helpful, Courteous, and Respectful Office Staff	63.5%	64.1%	59.5% ↓	69.6%
Received Information on Evening, Weekend, or Holiday Care	79.6%	75.3%	73.8% ↓	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	20.8%+	37.9%+	31.0%+	43.1%
Reminders About Child's Care from Provider Office	59.9%	53.6%	58.4% ↓	69.7%
Saw Provider Within 15 Minutes of Appointment	29.6%	30.7%	37.5% ↓	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, HCI's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to HCI's FY 2019–2020 results.

HCI: Strengths

While HSAG found that no scores for FY 2020–2021 were at or above the Colorado RAE aggregate rate for the child population, HSAG found that HCI's scores for nine measures were higher in FY 2020–2021 compared to FY 2019–2020:

- *Rating of Provider*
- *Rating of All Health Care*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Providers' Use of Information to Coordinate Patient Care*
- *Comprehensiveness—Child Development*
- *Reminders About Child's Care from Provider Office*
- *Saw Provider Within 15 Minutes of Appointment*

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

While all HCI's scores for the child population were lower in FY 2020–2021 than the FY 2020–2021 Colorado RAE aggregate score, HCI scored statistically significantly lower than the Colorado RAE aggregate on seven measures:

- *Getting Timely Appointments, Care, and Information*
- *Comprehensiveness—Child Development*
- *Comprehensiveness—Child Safety and Healthy Lifestyles*
- *Helpful, Courteous, and Respectful Office Staff*
- *Received Information on Evening, Weekend, or Holiday Care*
- *Reminders About Child's Care from Provider Office*
- *Saw Provider Within 15 Minutes of Appointment*

All of these measures are related to the quality domain, while *Getting Timely Appointments, Care, and Information* is also related to both the timeliness and access domains. In addition, *Received Information on Evening, Weekend, or Holiday Care* is also related to the access domain and *Saw Provider Within 15 Minutes of Appointment* is also related to the timeliness domain. HSAG recommends that HCI explore factors that may be contributing to low experience scores for these measures and develop initiatives designed to improve performance. Examples may include provider training or messaging on child development and lifestyles, practice guidelines, or communication skills. HSAG recommends that HCI further explore perceptions regarding those measures.

Region 5—Colorado Access

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-37 and Table 3-38 display the FY 2020–2021 validation findings for COA Region 5's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, COA Region 5 completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, COA Region 5 defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that COA Region 5 defined for the two PIP outcome measures in Module 1 are provided in Table 3-37.

Table 3-37—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in Well Visits among members aged 12 and older who receive care at Every Child Pediatrics and Inner City Health Center from 56.39% to 61.99%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 and older within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Inner City Health Center from 44.18% to 70.59%.

In Module 2—Intervention Determination, COA Region 5 conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, COA Region 5 updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by COA Region 5 in Module 2 are summarized for the two PIP outcome measures in Table 3-38. The PIP had not progressed to the point of deploying and testing interventions. The interventions that COA Region 5 ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-38—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider standards of care and coding consistency. • Depression screening occurs at every well visit. • Member engagement and education. • Appointment availability and access.
Potential Interventions	• Standardization of depression screen scoring. • Provider education on appropriate coding practices. • Promotion of telehealth options for well visits. • Automated well visit scheduling and reminder outreach. • Member education on appointment access and availability services.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider standards of care for behavioral health referral process. • Provider education on appropriate behavioral health follow-up coding practices. • Internal and external provider availability for behavioral health follow-up visits. • Member access, knowledge, and engagement.
Potential Interventions	• Targeted provider education on effective referral processes. • Provider workflow improvement and standardization. • Provider education on appropriate coding practices. • Expand telehealth follow-up options through COA's free VCCI program. • Develop member resources for behavioral health and referral resources.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, COA Region 5 will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. COA Region 5 will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

COA Region 5: Strengths

The validation findings suggest that COA Region 5 was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. COA Region 5 also successfully used QI

science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As COA Region 5 continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- COA Region 5 should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as COA Region 5 progresses through determining and testing interventions.
- COA Region 5 should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, COA Region 5 should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-39 shows the performance measure results for COA Region 5 PMV FY 2018–2019 and FY 2019–2020.

Table 3-39—Performance Measure Results for COA Region 5

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	43.54%	35.29%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	63.56%	73.69%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	37.22%	37.42%	50.63%
Follow-Up After a Positive Depression Screen	32.20%	45.87%	65.10%

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Behavioral Health Screening or Assessment for Children in the Foster Care System	17.20%	20.79%	27.42%

COA Region 5: Strengths

For the PMV, COA Region 5 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 Region 5 was above the statewide average for three out of the five indicators.

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

COA Region 5 fell below the statewide average for two out of the five indicators. COA Region 5 reported the lowest rates for *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Follow-Up After a Positive Depression Screen*. HSAG recommends that COA Region 5 assess interventions that have been successful for similar indicators to determine if any intervention(s) and/or initiative(s) may be effective to improve rates and performance for each identified measure. Additionally, COA Region 5 may want to consider creating a dashboard to view rates in real time and to create internal interim goals for each indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 5 Overall Evaluation

Table 3-40 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 2020–2021.

Table 3-40—Summary of COA Region 5 Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	16	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**69**	**0**	**0**	**0**	**100%***

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

Table 3-41 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 2020–2021.

Table 3-41—Summary of COA Region 5 Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)*
Credentialing	100	84	84	0	16	100%
Recredentialing	90	77	77	0	13	100%
Totals	**190**	**161**	**161**	**0**	**29**	**100%****

**COA Credentialing record review scores are based on a combined score for COA Region 3 and COA Region 5.*

***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

Efforts to retain quality providers included provider newsletters, support from provider relations, and occasional webinars/calls for idea sharing. Staff members described plans to improve assessment of new providers and monitoring of the existing network in 2021, using the expansion of Colorado's SUD benefit to launch this new approach. Compliance policies and procedures included thorough details about training content, and compliance staff members developed numerous tailored trainings, which were deployed in various departments. Clear and effective lines of communication and expectations for prompt reporting were evident in the submitted materials as well as comprehensive information about fraud, waste, and abuse. COA Region 5 operated a three-tiered Compliance Committee structure, which included the management level, the executive team, and the board of directors for wide-ranging oversight.

COA Region 5's credentialing and provider support department demonstrated extensive policies and procedures for credentialing and recredentialing providers. These procedures followed NCQA credentialing and recredentialing standards and demonstrated a uniform approach to assess provider applications. Documentation demonstrated thorough review criteria, sources for verification, and file management steps to ensure accurate and timely credentialing decisions were made. A review of credentialing, recredentialing, and organizational credentialing records demonstrated 100 percent compliance with timely initial and ongoing reviews, which included all key criteria within verification time limits.

Each selected delegation agreement outlined the delegated activities, indicated that the contractor agreed to perform the delegated activities, and included provisions for COA Region 5 to take action, including revocation, if the contracted entity failed to meet its obligations. In the agreements reviewed, COA Region 5 included language that the delegated entity was required to adhere to CMS requirements and State laws, retain records for 10 years, and allow for an audit upon the request of COA Region 5 or any regulatory body. In the event that a delegate did not meet required standards, COA Region 5 maintained policies and procedures to enact CAPs.

COA Region 5's QAPI Program Description and Annual Quality Report described a comprehensive QAPI program that outlined mechanisms to address care appropriateness, safety, quality, and member experience. Staff members reported that health information data were collected and managed through multiple systems and configured through COA Region 5's enterprise data warehouse. COA Region 5 described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance metrics, and identify cost and care trends for use across the organization.

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

HSAG identified no areas for opportunity that lead to required actions for the four standards reviewed in FY 2020–2021.

Validation of Network Adequacy

COA Region 5: Strengths

COA Region 5 participated in all quarterly network adequacy reporting and the Department publishes COA Region 5's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While COA Region 5 did not meet all minimum time and distance requirements across all counties in each county designation, COA Region 5's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, COA Region 5 should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-42 presents COA Region 5's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-42—Self-Reported EDV Results by Data Element and BH Service Category for COA Region 5

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 cases)
Procedure Code	NA	35.8%	92.7%
Principal Surgical Procedure Code	94.2%	NA	NA
Diagnosis Code	94.9%	81.8%	97.8%
Place of Service	NA	72.3%	94.2%
Service Category Modifier	NA	35.8%	92.7%
Units	NA	94.9%	97.8%
Revenue Code	98.5%	NA	NA
Discharge Status	96.4%	NA	NA
Service Start Date	96.4%	94.9%	97.8%
Service End Date	96.4%	94.9%	97.8%
Population	NA	94.9%	97.8%
Duration	NA	85.5%	97.8%
Staff Requirement	NA	94.9%	97.1%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-43 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with COA Region 5's EDV results for each of the validated data elements.

Table 3-43—BH EDV Over-Read Agreement Results by BH Service Category for COA Region 5

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	70.0%	90.0%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	100%	100%	100%
Place of Service	NA	100%	100%
Service Category Modifier	NA	60.0%	100%
Units	NA	100%	100%
Revenue Code	100%	NA	NA
Discharge Status	100%	NA	NA
Service Start Date	100%	100%	100%
Service End Date	100%	100%	100%
Population	NA	100%	100%
Duration	NA	100%	100%
Staff Requirement	NA	90.0%	90.0%

NA indicates that a data element was not evaluated for the specified service category.

COA Region 5: Strengths

COA Region 5 self-reported high overall accuracy for the inpatient services and residential services categories and generally high accuracy within the psychotherapy services category. Additionally, HSAG's over-read findings suggest a high level of confidence that COA Region 5's EDV results accurately reflect its encounter data quality. HSAG was in 100 percent agreement with all six inpatient services data elements, seven of the 10 psychotherapy services data elements, and eight of the 10 residential services data elements.

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

While over-read results suggest confidence in COA Region 5's EDV results, some of COA Region 5's self-reported EDV results themselves demonstrated a low level of encounter data accuracy. Within the psychotherapy services category, COA Region 5 had the lowest rate of agreement within the *Service Category Modifier* and *Procedure Code* data elements and overall low to moderate results within self-reported accuracy scores, including 35.8 percent accuracy for the *Service Category Modifier* data element. As such, COA Region 5 may consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

PCMH CAHPS Survey

COA Region 5: Adult PCMH CAHPS

Table 3-44 shows the adult PCMH CAHPS results for COA Region 5 for FY 2018–2019 through FY 2020–2021.

Table 3-44—Adult PCMH CAHPS Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	62.2%	65.0%	59.7% ↓	68.0%
Rating of Specialist Seen Most Often	56.7%	68.4%	61.3%	65.9%
Rating of All Health Care	55.2%	59.8%	55.8% ↓	64.0%
Rating of Health Plan	61.3%	66.1%	65.9%	65.8%
Getting Timely Appointments, Care, and Information	53.8%	56.7%	50.1%	49.0%
How Well Providers Communicate with Patients	69.6%	75.7%	66.5% ↓	76.2%
Providers' Use of Information to Coordinate Patient Care	58.6%	64.2%	52.9% ↓	63.3%
Talking with You About Taking Care of Your Own Health	44.6%	47.5%	48.4%	50.3%
Comprehensiveness	43.2%	43.7%	38.7% ↓	53.5%
Helpful, Courteous, and Respectful Office Staff	68.3%	73.9%	66.5% ↓	69.2%
Health First Colorado Customer Service	59.8%	66.9%+	57.4%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.9%	24.6%+	25.5%+	25.9%
Reminders About Care from Provider Office	65.7%	69.4%	69.4%	73.3%
Saw Provider Within 15 Minutes of Appointment	34.5%	39.3%	37.4% ↓	43.1%
Receive Health Care and Mental Health Care at Same Place	58.3%	57.4%	57.1%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, COA Region 5's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to COA Region 5's FY 2019–2020 results.

COA Region 5: Strengths

For the adult population, HSAG found that two measures scored higher than the Colorado RAE aggregate score in FY 2020–2021 (*Rating of Health Plan* and *Getting Timely Appointments, Care, and Information*), although not statistically significantly higher. Additionally, while still lower than the aggregate rate, COA Region 5's scores for two measures were higher in FY 2020–2021 than in FY 2019–2020 (*Talking with You About Taking Care of Your Own Health* and *Received Care from Provider Office During Evenings, Weekends, or Holidays*).

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 lower than the Colorado RAE aggregate rate on all measures except two, and statistically significantly lower than the Colorado RAE aggregate on seven measures:

- *Rating of Provider*
- *Rating of All Health Care*
- *How Well Providers Communicate with Patients*
- *Providers' Use of Information to Coordinate Patient Care*
- *Comprehensiveness*
- *Helpful, Courteous, and Respectful Office Staff*
- *Saw Provider Within 15 Minutes of Appointment*

HSAG recommends that COA Region 5 explore factors that may be contributing to low experience scores for measures and develop initiatives designed to improve member perceptions of quality. Examples may be increased training or messaging for providers related to communication skills or to encourage provision of timely care and referrals to care coordination.

COA Region 5: Child PCMH CAHPS

Table 3-45 shows the child PCMH CAHPS results for COA Region 5 for FY 2018–2019 through FY 2020–2021.

Table 3-45—Child PCMH CAHPS Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	81.2%	90.1%	87.8% ↑	79.7%
Rating of Specialist Seen Most Often	74.8%+	70.4%+	72.4%+	70.3%
Rating of All Health Care	81.9%	89.7%	88.9% ↑	79.2%
Getting Timely Appointments, Care, and Information	75.2%	74.8%+	77.3% ↑	67.7%
How Well Providers Communicate with Child	84.7%	85.4%+	90.9% ↑	80.0%
How Well Providers Communicate with Parents or Caretakers	84.8%	86.4%	88.5% ↑	83.5%
Providers' Use of Information to Coordinate Patient Care	74.5%	84.2%+	79.4%	74.8%
Comprehensiveness—Child Development	69.8%	75.7%	74.8% ↑	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	62.8%	67.4%	65.0% ↑	61.8%
Helpful, Courteous, and Respectful Office Staff	79.5%	82.5%	83.5% ↑	69.6%
Received Information on Evening, Weekend, or Holiday Care	82.4%	85.9%	88.4% ↑	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	56.0%+	49.6%+	58.7%+	43.1%
Reminders About Child's Care from Provider Office	75.6%	73.9%	80.7% ↑	69.7%
Saw Provider Within 15 Minutes of Appointment	51.0%	48.2%	59.8% ↑	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, COA Region 5's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to COA Region 5's FY 2019–2020 results.

COA Region 5: Strengths

For the child population, COA Region 5's scores for nine measures were higher in FY 2020–2021 compared to FY 2019–2020:

- *Rating of Specialist Seen Most Often*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Helpful, Courteous, and Respectful Office Staff*
- *Received Information on Evening, Weekend, or Holiday Care*
- *Received Care from Provider Office During Evenings, Weekends, or Holidays*
- *Reminders About Child's Care from Provider Office*
- *Saw Provider Within 15 Minutes of Appointment*

In addition, COA Region 5 scored higher than the Colorado RAE aggregate on all measures and significantly higher than the Colorado RAE aggregate on the following 11 measures:

- *Rating of Provider*
- *Rating of All Health Care*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Comprehensiveness—Child Development*
- *Comprehensiveness—Child Safety and Healthy Lifestyles*
- *Helpful, Courteous, and Respectful Office Staff*
- *Received Information on Evening, Weekend, or Holiday Care*
- *Reminders About Child's Care from Provider Office*
- *Saw Provider Within 15 Minutes of Appointment*

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

HSAG found that no child measure rates were lower than the Colorado RAE aggregate rate and, therefore, found no specific opportunities for improvement for COA Region 5's child PCMH CAHPS results. HSAG recommends that COA Region 5 continue to explore perceptions regarding CAHPS measures and continue to strive for improvement in rates.

Region 6—Colorado Community Health Alliance

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-46 and Table 3-47 display the FY 2020–2021 validation findings for CCHA Region 6's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, CCHA Region 6 completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, CCHA Region 6 defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that CCHA Region 6 defined for the two PIP outcome measures in Module 1 are provided in Table 3-46.

Table 3-46—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Clinica Family Health (Lafayette and Peoples Clinics) among CCHA members 12 years or older from 52.18% to 58.41%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Clinica Family Health (Lafayette and Peoples Clinics) among CCHA members 12 years or older from 80.9% to 97.92%.

In Module 2—Intervention Determination, CCHA Region 6 conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, CCHA Region 6 updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by CCHA Region 6 in Module 2 are summarized for the two PIP outcome measures in Table 3-47. The PIP had not progressed to the point of deploying and testing interventions. The interventions that CCHA Region 6 ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-47—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, CCHA Region 6 will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. CCHA Region 6 will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

CCHA Region 6: Strengths

The validation findings suggest that CCHA Region 6 was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. CCHA Region 6 also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As CCHA Region 6 continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- CCHA Region 6 should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as CCHA Region 6 progresses through determining and testing interventions.
- CCHA Region 6 should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, CCHA Region 6 should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-48 shows the performance measure results for CCHA Region 6 PMV FY 2018–2019 and FY 2019–2020.

Table 3-48—Performance Measure Results for CCHA Region 6

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	45.81%	46.37%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	69.45%	77.93%	81.79%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	35.25%	35.41%	50.63%
Follow-Up After a Positive Depression Screen	52.56%	61.75%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.59%	21.51%	27.42%

CCHA Region 6: Strengths

For the PMV, CCHA Region 6 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 Region 6 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 Region 6 fell below the statewide average for *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Follow-Up After a Positive Depression Screen*. HSAG recommends that CCHA Region 6 assess interventions that have been successful for similar indicators to determine if any intervention(s) and/or initiative(s) may be effective to improve rates and performance for each identified measure. Additionally, CCHA Region 6 may want to consider creating a dashboard to be able to view rates in real time and to create interim internal goals for each indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 6 Overall Evaluation

Table 3-49 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 2020–2021.

Table 3-49—Summary of CCHA Region 6 Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	15	15	0	0	1	100%
Standard VIII—Credentialing and Recredentialing	32	31	31	0	0	1	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**67**	**67**	**0**	**0**	**2**	**100%***

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

Table 3-50 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 2020–2021.

Table 3-50—Summary of CCHA Region 6 Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)*
Credentialing	100	86	86	0	14	100%
Recredentialing	90	75	75	0	15	100%
Totals	**190**	**161**	**161**	**0**	**29**	**100%****

**CCHA Credentialing record review scores are based on a combined score for CCHA Region 6 and CCHA Region 7.*

***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 Region 6's policies pertaining to the selection and retention of providers were comprehensive and depicted the processes used to recruit, select, contract, and retain providers. CCHA Region 6's Request to Join Provider Network policy noted that the RAE is willing to recruit and contract with any provider in good standing with CMS and enrolled in the Colorado Medicaid Program. CCHA Region 6 used service data and member inquiry trends to identify and prioritize recruiting efforts and gaps in the network. The regional Compliance Plan and supporting policies addressed staff and provider education and compliance activities that included claims reviews, data mining, auditing, and risk assessments. Employee training outlined methods for employees to recognize and submit concerns about fraud, waste, or abuse to the Special Investigations Unit (SIU).

Established policies, procedures, and supporting documents demonstrated systems in place to ensure that all credentialing and recredentialing processes meet NCQA, federal, and State specifications and requirements. Operational processes and procedures described a method for evaluating initial and recredentialing applications, verifying required credentialing elements, applicant record approval, decision making to determine denial or disenrollment of network participation, and notification of determination. Review of a sample of administrative records demonstrated CCHA Region 6's timely primary source verification of licenses, education/training, work history, history of professional liability, State/Medicaid sanctions/exclusions, and practitioner applications/attestations.

Staff members reported that CCHA Region 6 had seven agreements to delegate administrative activities with delegated services and responsibilities ranging from provider credentialing, language interpretation and translation services, and care coordination services. CCHA Region 6 maintained a set of policies that described the mechanisms in place for delegation and oversight of delegated activities. Submitted documents reflected ongoing reporting and oversight activities that included annual credentialing delegation audit reports. The department associated with the delegated function provided oversight of the corresponding delegates. Oversight procedures were described in a delegation policy for each functional area.

CCHA Region 6's QAPI program described the leadership structure, goals and objectives, and program components encompassing covered healthcare services. CCHA Region 6 established a multi-disciplinary Quality Management Committee (QMC), identified priority populations and programs, and defined processes related to each component of the QAPI program. Submitted HIS documents described a comprehensive system and data validation processes used. CCHA Region 6 verified the accuracy and timeliness of reported data and screened the data for completeness, logic, and consistency. The HIS collected and provided claims, encounters, grievance, appeal, utilization, and disenrollment data.

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

HSAG identified no areas for opportunity that lead to required actions for the four standards reviewed in FY 2020–2021.

Validation of Network Adequacy

CCHA Region 6: Strengths

CCHA Region 6 participated in all quarterly network adequacy reporting and the Department publishes CCHA Region 6's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While CCHA Region 6 did not meet all minimum time and distance requirements across all counties in each county designation, CCHA Region 6's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, CCHA Region 6 should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-51 presents CCHA Region 6's self-reported BH encounter data service coding accuracy results by service category and validated data element.[3-2]

Table 3-51—Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 6

Data Element	Ambulatory Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 cases)
Procedure Code	94.2%	89.8%	90.5%
Principal Surgical Code	NA	NA	NA
Diagnosis Code	79.6%	92.0%	97.1%
Place of Service	94.9%	94.2%	95.6%
Service Category Modifier	93.4%	89.8%	90.5%
Units	94.9%	96.4%	96.4%
Revenue Code	NA	NA	NA

[3-2] After distributing the lists of sampled cases to the RAEs, a RAE notified the Department that its Inpatient Services cases reflected services rendered in ambulatory settings, which would not align with the inpatient data fields designated for inclusion in the RAEs' EDV results. The Department instructed HSAG and CCHA Region 6 to consider sampled Inpatient Services cases with Place of Service codes other than "21" and "51" as professional services rendered in ambulatory settings, and to evaluate these cases using the non-inpatient data fields considered for the Psychotherapy Services and Residential Services cases. These cases are identified and reported in the EDV and HSAG's over-read as Ambulatory Inpatient Services cases and did not alter the overall number of CCHA Region 6's sampled cases; CCHA Region 6's over-read included no Inpatient Services cases.

Data Element	Ambulatory Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 cases)
Discharge Status	NA	NA	NA
Service Start Date	94.9%	97.1%	97.1%
Service End Date	94.9%	97.1%	97.1%
Population	94.9%	97.1%	97.8%
Duration	94.9%	97.1%	97.1%
Staff Requirement	94.2%	93.4%	97.8%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-52 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with CCHA Region 6's EDV results for each of the validated data elements.

Table 3-52—BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 6

Data Element	Ambulatory Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	100%	80.0%	100%
Principal Surgical Procedure Code	NA	NA	NA
Diagnosis Code	100%	90.0%	90.0%
Place of Service	0.0%	100%	90.0%
Service Category Modifier	50.0%	100%	100%
Units	100%	100%	100%
Revenue Code	NA	NA	NA
Discharge Status	NA	NA	NA
Service Start Date	100%	100%	100%
Service End Date	100%	100%	90.0%
Population	100%	100%	100%
Duration	100%	100%	100%
Staff Requirement	100%	90.0%	90.0%

NA indicates that a data element was not evaluated for the specified service category.

CCHA Region 6: Strengths

CCHA Region 6's self-reported service accuracy scores were generally at or above 90 percent, and HSAG's over-read findings suggest a high level of confidence that CCHA Region 6's EDV results accurately reflect its encounter data quality. HSAG was in 100 percent agreement with eight of the 10

ambulatory inpatient services data elements, seven of the 10 psychotherapy services data elements, and six of the 10 residential services data elements.

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

While over-read results suggest confidence in CCHA Region 6's EDV results, some of CCHA Region 6's self-reported EDV results themselves demonstrated a low level of encounter data accuracy. At 0.0 percent, the *Place of Service* data element had the lowest rate of agreement between CCHA Region 6's EDV results and HSAG's over-read results. Eight of the 10 ambulatory inpatient services cases sampled for CCHA Region 6's over-read had a *Place of Service* data value of "77" and a *Procedure Code* data value of "H0031." However, the USCS manual does not define "77" as a valid *Place of Service* code and this value is not listed as a valid *Place of Service* code for encounters with the "H0031" procedure code. Furthermore, HSAG only agreed with 50 percent of the *Service Category Modifier* encounter data elements within the ambulatory inpatient services category. HSAG recommends that CCHA Region 6 update its internal procedures and conduct both internal and provider-facing trainings to clarify BH service coding accuracy expectations.

PCMH CAHPS Survey

CCHA Region 6: Adult PCMH CAHPS

Table 3-53 shows the adult PCMH CAHPS results for CCHA Region 6 for FY 2018–2019 through FY 2020–2021.

Table 3-53—Adult PCMH CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	61.1%	58.9%	69.0%	68.0%
Rating of Specialist Seen Most Often	55.3%	67.9%	64.3%	65.9%
Rating of All Health Care	55.8%	55.7%	67.7%	64.0%
Rating of Health Plan	57.6%	60.2%	66.5%	65.8%
Getting Timely Appointments, Care, and Information	43.4%	42.1%	44.6% ↓	49.0%
How Well Providers Communicate with Patients	71.5%	73.5%	77.4%	76.2%
Providers' Use of Information to Coordinate Patient Care	58.4%	61.1%	64.3%	63.3%
Talking with You About Taking Care of Your Own Health	51.0%	52.3%	50.1%	50.3%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Comprehensiveness	58.3%	56.5%	59.5% ↑	53.5%
Helpful, Courteous, and Respectful Office Staff	69.3%	65.1%	67.9%	69.2%
Health First Colorado Customer Service	56.4%	64.2%	65.1%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	22.2%	13.1%	19.4% ↓	25.9%
Reminders About Care from Provider Office	74.5%	74.7%	73.3%	73.3%
Saw Provider Within 15 Minutes of Appointment	32.9%	33.9%	41.9%	43.1%
Receive Health Care and Mental Health Care at Same Place	58.5%	60.4%	60.8%	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, CCHA Region 6's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to CCHA Region 6's FY 2019–2020 results.

CCHA Region 6: Strengths

For the adult population, CCHA Region 6's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except three: *Rating of Specialist Seen Most Often*, *Talking with You About Taking Care of Your Own Health*, and *Reminders About Care from Provider Office*. In addition, CCHA Region 6 scored higher than the Colorado RAE aggregate rate on seven rates, with one measure being statistically significantly higher than the Colorado RAE aggregate, *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 lower than the Colorado RAE aggregate on seven measures with two measures being statistically significantly lower: *Getting Timely Appointments, Care, and Information* and *Received Care from Provider Office During Evenings, Weekends, or Holidays*.

HSAG recommends that CCHA Region 6 explore factors that may be contributing to low experience scores and develop initiatives designed to improve member perceptions. While these two scores remain lower than the aggregate rate, they were higher than scores for FY 2019–2020. HSAG recommends that CCHA Region 6 explore what may have driven the higher rates in the practices surveyed in FY 2020–2021 to determine if there are best practices that can be shared or duplicated.

CCHA Region 6: Child PCMH CAHPS

Table 3-54 shows the child PCMH CAHPS results for CCHA Region 6 for FY 2018–2019 through FY 2020–2021.

Table 3-54—Child PCMH CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	81.2%	68.2%	81.4%	79.7%
Rating of Specialist Seen Most Often	66.1%+	82.3%	76.8%+	70.3%
Rating of All Health Care	76.5%	71.6%	78.8%	79.2%
Getting Timely Appointments, Care, and Information	72.3%	61.5%	79.6% ↑	67.7%
How Well Providers Communicate with Child	79.5%	78.3%	85.9% ↑	80.0%
How Well Providers Communicate with Parents or Caretakers	84.1%	78.0%	86.8% ↑	83.5%
Providers' Use of Information to Coordinate Patient Care	78.2%	72.8%	81.5%	74.8%
Comprehensiveness—Child Development	67.7%	69.0%	73.8% ↑	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	58.1%	66.1%	66.9% ↑	61.8%
Helpful, Courteous, and Respectful Office Staff	80.8%	65.6%	85.4% ↑	69.6%
Received Information on Evening, Weekend, or Holiday Care	86.1%	76.5%	86.0%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	31.7%+	32.5%	40.9%+	43.1%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Reminders About Child's Care from Provider Office	72.5%	72.5%	69.7%	69.7%
Saw Provider Within 15 Minutes of Appointment	54.8%	40.4%	67.6% ↑	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, CCHA Region 6's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to CCHA Region 6's FY 2019–2020 results.

CCHA Region 6: Strengths

For the child population, CCHA Region 6's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except two: *Rating of Specialist Seen Most Often* and *Reminders About Child's Care from Provider Office*. In addition, CCHA Region 6 scored statistically significantly higher than the Colorado RAE aggregate on seven measures:

- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Comprehensiveness—Child Development*
- *Comprehensiveness—Child Safety and Healthy Lifestyles*
- *Helpful, Courteous, and Respectful Office Staff*
- *Saw Provider Within 15 Minutes of Appointment*

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

For the child population, HSAG found that two measures scored lower than the Colorado RAE aggregate score in FY 2020–2021 (*Rating of All Health Care* and *Received Care from Provider Office During Evenings, Weekends, or Holidays*), although these were not statistically significantly lower.

HSAG recommends that CCHA Region 6 explore factors that may be contributing to low experience scores and develop initiatives designed to improve member perceptions. While these two scores remain lower than the aggregate rate, they were higher than scores for FY 2019–2020. HSAG recommends that CCHA Region 6 explore what may have driven the higher rates in the practices surveyed in FY 2020–2021 to determine if there are best practices that can be shared or duplicated.

Region 7—Colorado Community Health Alliance

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-55 and Table 3-56 display the FY 2020–2021 validation findings for CCHA Region 7's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, CCHA Region 7 completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, CCHA Region 7 defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that CCHA Region 7 defined for the two PIP outcome measures in Module 1 are provided in Table 3-55.

Table 3-55—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 52.12% to 54.81%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 90.3% to 96.7%.

In Module 2—Intervention Determination, CCHA Region 7 conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, CCHA Region 7 updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by CCHA Region 7 in Module 2 are summarized for the two PIP outcome measures in Table 3-56. The PIP had not progressed to the point of deploying and testing interventions. The interventions that CCHA Region 7 ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-56—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, CCHA Region 7 will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. CCHA Region 7 will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

CCHA Region 7: Strengths

The validation findings suggest that CCHA Region 7 was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. CCHA Region 7 also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As CCHA Region 7 continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- CCHA Region 7 should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as CCHA Region 7 progresses through determining and testing interventions.
- CCHA Region 7 should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, CCHA Region 7 should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Performance Measure Rates and Validation

Table 3-57 shows the performance measure results for CCHA Region 7 PMV FY 2018–2019 and FY 2019–2020.

Table 3-57—Performance Measure Results for CCHA Region 7

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	55.01%	46.37%	60.52%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	72.90%	77.93%	81.79%

Performance Measure	FY 2018–2019	FY 2019–2020	FY 2019–2020 Performance Target
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	37.01%	35.41%	50.63%
Follow-Up After a Positive Depression Screen	59.18%	61.75%	65.10%
Behavioral Health Screening or Assessment for Children in the Foster Care System	19.47%	21.51%	27.42%

CCHA Region 7: Strengths

For the PMV, CCHA Region 7 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 Region 7 was above the statewide average for four out of five indicators. It reported the highest rates for *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Follow-Up After a Positive Depression Screen*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

CCHA Region 7 was above the statewide average for all five indicators. However, to continue to strive toward improvement, CCHA Region 7 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.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 7 Overall Evaluation

Table 3-58 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 2020–2021.

Table 3-58—Summary of CCHA Region 7 Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	15	15	0	0	1	100%
Standard VIII—Credentialing and Recredentialing	32	31	31	0	0	1	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**67**	**67**	**0**	**0**	**2**	**100%***

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

Table 3-59 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 2020–2021.

Table 3-59—Summary of CCHA Region 7 Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)*
Credentialing	100	86	86	0	14	100%
Recredentialing	90	75	75	0	15	100%
Totals	**190**	**161**	**161**	**0**	**29**	**100%****

**CCHA Credentialing record review scores are based on a combined score for CCHA Region 6 and CCHA Region 7.*

***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 Region 7's policies pertaining to the selection and retention of providers were comprehensive and depicted the processes used to recruit, select, contract, and retain providers. CCHA Region 7's Request to Join Provider Network policy noted that the RAE is willing to recruit and contract with any provider in good standing with CMS and enrolled in the Colorado Medicaid Program. CCHA Region 7 used service data and member inquiry trends to identify and prioritize recruiting efforts and gaps in the network. The regional Compliance Plan and supporting policies addressed staff and provider education and compliance activities that included claims reviews, data mining, auditing, and risk assessments. Employee training outlined methods for employees to recognize and submit concerns about fraud, waste, or abuse to the SIU.

Established policies, procedures, and supporting documents demonstrated systems in place to ensure that all credentialing and recredentialing processes meet NCQA, federal, and State specifications and requirements. Operational processes and procedures described a method for evaluating initial and recredentialing applications, verifying required credentialing elements, applicant record approval, decision making to determine denial or disenrollment of network participation, and notification of determination. Review of a sample of administrative records demonstrated CCHA Region 7's timely primary source verification of licenses, education/training, work history, history of professional liability, State/Medicaid sanctions/exclusions, and practitioner applications/attestations.

Staff members reported that CCHA Region 7 had six agreements to delegate administrative services and responsibilities including provider credentialing, language interpretation and translation services, and care coordination services. CCHA Region 7 maintained a set of policies that described the mechanisms in place for delegation and oversight of delegated activities. Submitted documents reflected ongoing reporting and oversight activities that included annual credentialing delegation audits. The department associated with the delegated function provided oversight of the corresponding delegates. Oversight procedures were described in a delegation policy for each functional area.

CCHA Region 7's QAPI program described the leadership structure, goals and objectives, and program components encompassing covered healthcare services. CCHA Region 7 established a multi-disciplinary QMC, identified priority populations and programs, and defined processes related to each component of the QAPI program. Submitted HIS documents described a comprehensive system and data validation processes used. CCHA Region 7 verified the accuracy and timeliness of reported data and screened the data for completeness, logic, and consistency. The HIS collected and provided claims, encounters, grievance, appeal, utilization, and disenrollment data.

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

HSAG identified no required actions for the four standards reviewed in FY 2020–2021.

Validation of Network Adequacy

CCHA Region 7: Strengths

CCHA Region 7 participated in all quarterly network adequacy reporting and the Department publishes CCHA Region 7's reports here: Accountable Care Collaborative Deliverables | Colorado Department of Health Care Policy & Financing. While CCHA Region 7 did not meet all minimum time and distance requirements across all counties in each county designation, CCHA Region 7's NAV report includes the RAE's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

To support accurate network information that facilitates members' access to care, CCHA Region 7 should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-60 presents CCHA Region 7's self-reported BH encounter data service coding accuracy results by service category and validated data element.[3-3]

Table 3-60—Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 7

Data Element	Ambulatory Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	94.2%	86.9%	88.3%
Principal Surgical Code	NA	NA	NA
Diagnosis Code	94.2%	89.8%	96.4%

[3-3] After distributing the lists of sampled cases to the RAEs, a RAE notified the Department that its Inpatient Services cases reflected services rendered in ambulatory settings, which would not align with the inpatient data fields designated for inclusion in the RAEs' EDV results. The Department instructed HSAG and CCHA Region 7 to consider sampled Inpatient Services cases with Place of Service codes other than "21" and "51" as professional services rendered in ambulatory settings, and to evaluate these cases using the non-inpatient data fields considered for the Psychotherapy Services and Residential Services cases. These cases are identified and reported in the EDV and HSAG's over-read as Ambulatory Inpatient Services cases and did not alter the overall number of CCHA Region 7's sampled cases; CCHA Region 7's over-read included no Inpatient Services cases.

Data Element	Ambulatory Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Place of Service	92.7%	94.9%	98.5%
Service Category Modifier	94.2%	86.9%	89.1%
Units	94.9%	94.2%	99.3%
Revenue Code	NA	NA	NA
Discharge Status	NA	NA	NA
Service Start Date	94.9%	94.9%	99.3%
Service End Date	94.9%	94.9%	98.5%
Population	94.9%	94.9%	99.3%
Duration	94.9%	93.4%	99.3%
Staff Requirement	94.9%	94.2%	79.6%

NA indicates that a data element was not evaluated for the specified service category.

Table 3-61 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with CCHA Region 7's EDV results for each of the validated data elements.

Table 3-61—BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 7

Data Element	Ambulatory Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	90.0%	100%	100%
Principal Surgical Procedure Code	NA	NA	NA
Diagnosis Code	90.0%	100%	100%
Place of Service	0.0%	100%	100%
Service Category Modifier	40.0%	100%	100%
Units	90.0%	100%	100%
Revenue Code	NA	NA	100%
Discharge Status	NA	NA	NA
Service Start Date	90.0%	100%	100%
Service End Date	90.0%	100%	100%
Population	90.0%	100%	100%
Duration	90.0%	100%	100%
Staff Requirement	90.0%	100%	100%

NA indicates that a data element was not evaluated for the specified service category.

CCHA Region 7: Strengths

CCHA Region 7's self-reported service accuracy scores were generally at or above 90 percent, and HSAG's over-read findings suggest a high level of confidence that CCHA Region 7's EDV results accurately reflect its encounter data quality. HSAG's reviewers agreed with 90 percent of eight of the 10 validated data elements for ambulatory inpatient services, and 100 percent for all 10 validated data elements for both psychotherapy services and residential services.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

While over-read results suggest confidence in CCHA Region 7's EDV results, some of CCHA Region 7's self-reported EDV results themselves demonstrated a low level of encounter data accuracy. At 0.0 percent, the *Place of Service* data element had the lowest rate of agreement between CCHA Region 7's EDV results and HSAG's over-read results. Nine of the ambulatory inpatient services cases sampled for CCHA Region 7's over-read had a *Place of Service* data value of "77" and a *Procedure Code* data value of "H0031." However, the USCS manual does not define "77" as a valid *Place of Service* code and this value is not listed as a valid *Place of Service* code for encounters with the "H0031" procedure code. Furthermore, *Service Category Modifier* received only 40 percent agreement. HSAG recommends that CCHA Region 7 update its internal procedures and conduct both internal and provider-facing trainings to clarify BH service coding accuracy.

PCMH CAHPS Survey

CCHA Region 7: Adult PCMH CAHPS

Table 3-62 shows the adult PCMH CAHPS results for CCHA Region 7 for FY 2018–2019 through FY 2020–2021.

Table 3-62—Adult PCMH CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	74.9%	54.6%	68.7%	68.0%
Rating of Specialist Seen Most Often	65.0%	61.2%	67.9%	65.9%
Rating of All Health Care	67.6%	52.1%	65.8%	64.0%
Rating of Health Plan	60.5%	57.6%	63.8%	65.8%
Getting Timely Appointments, Care, and Information	54.3%	50.8%	53.2%	49.0%
How Well Providers Communicate with Patients	82.4%	68.9%	80.5% ↑	76.2%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Providers' Use of Information to Coordinate Patient Care	68.4%	53.4%	69.0% ↑	63.3%
Talking with You About Taking Care of Your Own Health	53.5%	43.5%	51.6%	50.3%
Comprehensiveness	60.1%	46.9%	55.2% ↑	53.5%
Helpful, Courteous, and Respectful Office Staff	71.6%	73.7%	70.0%	69.2%
Health First Colorado Customer Service	66.0%+	65.2%	60.2%	63.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	28.8%+	29.2%	20.1%+	25.9%
Reminders About Care from Provider Office	76.8%	69.4%	77.3%	73.3%
Saw Provider Within 15 Minutes of Appointment	44.2%	40.3%	50.7% ↑	43.1%
Receive Health Care and Mental Health Care at Same Place	51.2%	53.2%	49.7% ↓	62.3%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, CCHA Region 7's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to CCHA Region 7's FY 2019–2020 results.

CCHA Region 7: Strengths

For the adult population, CCHA Region 7's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except four: *Helpful, Courteous, and Respectful Office Staff*; *Health First Colorado Customer Service*; *Received Care from Provider Office During Evenings, Weekends, or Holidays*; and *Receive Health Care and Mental Health Care at Same Place*. In addition, CCHA Region 7 scored statistically significantly higher than the Colorado RAE aggregate on four measures: *How Well Providers Communicate with Patients*; *Providers' Use of Information to Coordinate Patient Care*; *Comprehensiveness*; and *Saw Provider Within 15 Minutes of Appointment*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the adult population, CCHA Region 7 scored statistically significantly lower than the Colorado RAE aggregate on one measure, *Receive Health Care and Mental Health Care at Same Place*. Also, CCHA Region 7's FY 2020–2021 scores for three additional measures were lower than the Colorado RAE aggregate: *Rating of Health Plan*; *Health First Colorado Customer Service*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*.

HSAG recommends that CCHA Region 7 explore reasons the practices surveyed in FY 2020–2021 scored higher than practices surveyed in previous years and determine if any best practices can be shared with other practices and actions duplicated to improve scores. Also, HSAG recommends that the Department work with CCHA Region 7 to develop initiatives to improve areas with lower scores compared to the Colorado RAE aggregate.

CCHA Region 7: Child PCMH CAHPS

Table 3-63 shows the child PCMH CAHPS results for CCHA Region 7 for FY 2018–2019 through FY 2020–2021.

Table 3-63—Child PCMH CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Rating of Provider	78.3%	74.6%	81.5%	79.7%
Rating of Specialist Seen Most Often	71.6%	75.2%	72.2%	70.3%
Rating of All Health Care	77.5%	72.8%	80.8%	79.2%
Getting Timely Appointments, Care, and Information	73.4%	65.1%	77.0% ↑	67.7%
How Well Providers Communicate with Child	83.7%	82.1%	81.1%	80.0%
How Well Providers Communicate with Parents or Caretakers	85.3%	81.8%	88.3% ↑	83.5%
Providers' Use of Information to Coordinate Patient Care	72.6%	73.1%	74.1%	74.8%
Comprehensiveness—Child Development	64.9%	66.0%	70.7%	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	55.1%	56.7%	61.4%	61.8%

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Colorado RAE Aggregate
Helpful, Courteous, and Respectful Office Staff	71.2%	67.5%	74.3%	69.6%
Received Information on Evening, Weekend, or Holiday Care	82.7%	82.4%	83.7%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	43.0%+	36.4%	45.5%+	43.1%
Reminders About Child's Care from Provider Office	70.0%	72.9%	69.0%	69.7%
Saw Provider Within 15 Minutes of Appointment	46.2%	44.5%	50.9%	46.5%

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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Due to differences in selected practices between survey years, CCHA Region 7's FY 2020–2021 and FY 2018–2019 results presented in this report are not comparable to CCHA Region 7's FY 2019–2020 results.

CCHA Region 7: Strengths

For the child population, CCHA Region 7's scores were higher in FY 2020–2021 compared to FY 2019–2020 for every measure except three: *Rating of Specialist Seen Most Often*, *How Well Providers Communicate with Child*, and *Reminders About Child's Care from Provider Office*. In addition, CCHA Region 7 scored higher than the Colorado RAE aggregate rate on 10 measures and statistically significantly higher than the Colorado RAE aggregate on two of those measures: *Getting Timely Appointments, Care, and Information* and *How Well Providers Communicate with Parents or Caretakers*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the child population, HSAG found that two measures scored lower than the Colorado RAE aggregate score in FY 2020–2021 (*Providers' Use of Information to Coordinate Patient Care*, *Comprehensiveness—Child Safety and Healthy Lifestyles*, and *Reminders About Child's Care from Provider Office*), although not statistically significantly lower. HSAG recommends that CCHA Region 7 further explore member perceptions that contribute to those measures. Potential quality initiatives may include provider training or messaging regarding practice guidelines or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) procedures.

Managed Care Organizations

Denver Health Medical Plan

Validation of DHMP's Performance Improvement Project

Validation Activities and Interventions

Table 3-64 and Table 3-65 display the FY 2020–2021 validation findings for DHMP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, DHMP completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, DHMP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that DHMP defined for the two PIP outcome measures in Module 1 are provided in Table 3-64.

Table 3-64—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58%.

In Module 2—Intervention Determination, DHMP conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, DHMP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by DHMP in Module 2 are summarized for the two PIP outcome measures in Table 3-65. The PIP had not progressed to the point of deploying and testing interventions. The interventions that DHMP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-65—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of depression screening in EMR and data systems. • Adequate appointment length to allow for depression screening.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation. • Expand inclusion of depression screening as a standard service provided at all primary care acute visits.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of behavioral health follow-up services in EMR and data systems. • Adequate appointment length to address positive depression screen. • Attendance of scheduled behavioral health follow-up appointment.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation. • Same-day warm handoff to in-clinic behavioral health provider following positive depression screen.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, DHMP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. DHMP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

DHMP: Strengths

The validation findings suggest that DHMP was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. DHMP also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for

members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As DHMP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- DHMP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as DHMP progresses through determining and testing interventions.
- DHMP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, DHMP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

HEDIS Measure Rates and Validation

DHMP: Information Systems Standards Review

According to the HEDIS MY 2020 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 3-66 shows the performance measure results for DHMP for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile ranking for each HEDIS MY 2020 rate.

Table 3-66—Performance Measure Results for DHMP

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	67.97%	69.65%	68.51%	10th–24th
Combination 3	64.72%	66.67%	67.98%	25th–49th
Combination 4	64.60%	66.35%	67.63%	25th–49th
Combination 5	56.73%	57.78%	58.07%	25th–49th
Combination 6	45.13%	48.03%	44.82%	50th–74th
Combination 7	56.61%	57.63%	57.81%	25th–49th
Combination 8	45.07%	48.03%	44.65%	50th–74th
Combination 9	40.69%	42.85%	40.26%	50th–74th
Combination 10	40.63%	42.85%	40.18%	50th–74th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	76.89%	78.06%	75.70%	10th–24th
Combination 2 (Meningococcal, Tdap, HPV)	49.46%	50.47%	**45.11%^^**	75th–89th
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	54.69%	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	57.13%	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	39.31%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	21.89%	25.11%	65.36%^	10th–24th
Counseling for Nutrition—Total	7.45%	9.16%	69.85%^	25th–49th
Counseling for Physical Activity—Total	5.90%	8.08%	69.19%^	50th–74th
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	84.53%	83.36%	10th–24th
Postpartum Care	—	66.50%	69.22%	10th–24th
Adults' Access to Preventive/Ambulatory Health Services				
Total	53.89%	55.30%	**51.52%^^**	<10th
Preventive Screening				
Chlamydia Screening in Women				
Total	69.58%	72.91%	**67.35%^^**	75th–89th
Breast Cancer Screening[1]				
Breast Cancer Screening	46.48%	46.01%	**42.60%^^**	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Cervical Cancer Screening[1]				
Cervical Cancer Screening	43.07%	45.58%	**41.11%^^**	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.04%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	54.20%	57.19%	61.14%	75th–89th
Effective Continuation Phase Treatment	33.96%	37.69%	40.73%	50th–74th
Follow-Up Care for Children Prescribed ADHD Medication[1]				
Initiation Phase	39.69%	41.35%	41.28%	25th–49th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	NA	50.00%	25th–49th
Cholesterol Testing—Total	—	NA	47.22%	75th–89th
Blood Glucose and Cholesterol Testing—Total	46.34%	NA	36.11%	50th–74th
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	46.88%	NA	NA	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing[1]	82.06%	83.00%	**73.18%^^**	<10th
*HbA1c Poor Control (>9.0%)**[,1]	40.38%	40.51%	**52.46%^^**	10th–24th
HbA1c Control (<8.0%)[1]	47.88%	48.96%	**38.41%^^**	10th–24th
Eye Exam (Retinal) Performed[1]	45.83%	45.70%	**36.25%^^**	<10th
Blood Pressure Control (<140/90 mm Hg)[2]	—	—	50.23%	—
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	57.75%	61.74%	60.67%	10th–24th
Statin Adherence 80%	60.63%	67.58%	67.46%	50th–74th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	72.41%	76.14%	73.66%	10th–24th
Statin Adherence 80%—Total	69.52%	64.18%	67.88%	25th–49th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	72.83%	77.62%	80.29%	75th–89th
Pharmacotherapy Management of COPD Exacerbation[1]				
Systemic Corticosteroid	50.34%	59.82%	**50.21%^^**	<10th
Bronchodilator	72.21%	74.49%	**65.02%^^**	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Asthma Medication Ratio				
Total	46.60%	46.60%	51.41%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.57%	26.19%	30.00%	50th–74th
Antibiotic Stewardship				
Appropriate Testing for Pharyngitis[1]				
Total	—	85.51%	**80.37%^^**	50th–74th
Appropriate Treatment for Upper Respiratory Infection				
Total	—	96.35%	97.50%	≥90th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Total	—	79.61%	82.92%	≥90th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.32	0.34	0.28	≥90th
Average Days Supplied per Antibiotic Script—Total	9.44	9.54	9.72	10th–24th
Average Scripts PMPY for Antibiotics of Concern—Total	0.09	0.10	0.08	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	28.74%	28.99%	29.13%	≥90th
Opioids				
Use of Opioids at High Dosage*[1]				
Use of Opioids at High Dosage	—	5.85%	4.40%	50th–74th
Use of Opioids From Multiple Providers*[1]				
Multiple Pharmacies	12.09%	6.17%	4.34%	50th–74th
Multiple Prescribers	18.61%	16.11%	14.92%	75th–89th
Multiple Prescribers and Multiple Pharmacies	6.32%	4.41%	3.28%	25th–49th
Risk of Continued Opioid Use*[1]				
At Least 15 Days Covered—Total	—	5.40%	4.25%	50th–74th
At Least 31 Days Covered—Total	—	2.35%	2.38%	50th–74th
Pharmacotherapy for Opioid Use Disorder[1]				
Total	—	15.91%	14.96%	<10th
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	43.95	45.35	33.75	≥90th
Outpatient Visits—Total	203.78	215.69	177.62	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	5.06	5.79	5.46	10th–24th
Total Average Length of Stay (Total Inpatient)	4.59	4.40	5.08	75th–89th
Total Discharges per 1,000 Member Months (Medicine)	2.90	3.39	3.25	50th–74th
Total Average Length of Stay (Medicine)	4.17	3.92	4.63	75th–89th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Surgery)	0.90	1.06	0.99	10th–24th
Total Average Length of Stay (Surgery)	8.49	8.23	9.42	≥90th
Total Discharges per 1,000 Member Months (Maternity)	1.72	1.80	1.58	10th–24th
Total Average Length of Stay (Maternity)	2.76	2.58	2.71	25th–49th
Plan All-Cause Readmissions*				
Observed Readmissions—Total	—	13.79%	11.35%	10th–24th
*O/E** Ratio—Total*	—	1.26	1.14	10th–24th

**For this indicator, a lower rate indicates better performance.*
*** O/E = Observed-to-Expected*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 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 MY 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 MY 2018 or HEDIS MY 2019.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

DHMP: Strengths

The following HEDIS MY 2020 measure rates were determined to be high-performing rates for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2019):

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Appropriate Treatment for Upper Respiratory Infection—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*

For HEDIS MY 2020, DHMP's performance for preventive screenings for young members was positive, with *Non-Recommended Screenings for Cervical Cancer in Adolescent Females* above the 90th percentile. DHMP's rate for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* showed statistically significant improvement and measured above the 50th percentile. Additionally, two measures within the Antibiotic Stewardship domain (*Appropriate Treatment for Upper Respiratory Infection—Total* and *Avoidance of*

Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total exceeded the 90th percentile, demonstrating strength in prescribing practices for conditions (i.e., common cold) that do not resolve with or are not aided by antibiotic treatment.

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

The following HEDIS MY 2020 measure rates were determined to be low-performing rates for DHMP (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2019):

- *Childhood Immunization Status—Combination 2*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *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*
- *Pharmacotherapy for Opioid Use Disorder—Total*

For HEDIS MY 2020, DHMP demonstrated opportunities to improve access to appropriate providers and services for child and adult members, as evidenced by all measures in the Access to Care domain and most measures in the Preventive Screening domain falling below the 25th percentile. Additionally, a couple measures within the Pediatric Care domain (i.e., *Childhood Immunization Status—Combination 2* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap*) 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 care for members.

Additionally, the MCO demonstrated opportunities to improve the care management of members with diabetes, as evidenced by the low rates of testing for HbA1c levels and retinal disease, along with the low prescribing rates of statin medication. Further, DHMP indicated improvement is needed related to the medication management for members with other chronic conditions (e.g., cardiovascular disease, asthma, chronic obstructive pulmonary disease [COPD]). The MCO should work with the Department to identify the factors contributing to the low rates for these measures (e.g., are the barriers related to accessing outpatient care and pharmacies; or the need for provider training, investigation of prescribing

patterns, or improved community outreach and education) and implement strategies to improve care for members with chronic conditions.

Assessment of Compliance With Medicaid Managed Care Regulations

DHMP Overall Evaluation

Table 3-67 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 2020–2021.

Table 3-67—Summary of DHMP Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	15	15	0	0	1	100%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Standard X—Quality Assessment and Performance Improvement	17	17	16	1	0	0	94%
Totals	**69**	**68**	**66**	**2**	**0**	**1**	**97%***

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

Table 3-68 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 2020–2021.

Table 3-68—Summary of DHMP Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	96	96	0	4	100%
Recredentialing	90	86	86	0	4	100%
Totals	**190**	**182**	**182**	**0**	**8**	**100%***

**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: Trended Performance for Compliance With Regulations

Table 3-69—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 III—Coordination and Continuity of Care (2015–2016, 2018–2019)	92%	70%
Standard IV—Member Rights and Protections (Includes Confidentiality) (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 (Selection) and Program Integrity (2017–2018, 2020–2021)	**80%**	**100%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2020–2021)	**98%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**0%**	**75%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2020–2021)	**88%**	**94%**
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 2020–2021.

Trended scores over the past two review cycles indicate that DHMP improved performance in all four standards reviewed in FY 2020–2021. DHMP's scores improved substantially (10 percentage points or more) for Standard VII—Provider Participation (Selection) and Program Integrity, which increased by 20 percentage points from 80 to 100 percent, and for Standard IX—Subcontractual Relationships and Delegation, which improved from 0 percent compliance to 75 percent compliance. Slight improvements were noted for Standard VIII—Credentialing and Recredentialing, which improved from 98 percent compliance to 100 percent, and Standard X—Quality Assessment and Performance Improvement, which improved from 88 percent to 94 percent.

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, with particular consideration to the four lowest scoring standards:

Standard III—Coordination and Continuity of Care, Standard IX—Subcontractual Relationships and Delegation, Standard V—Member Information, and Standard VI—Grievance and Appeal Systems.

DHMP: Strengths

Policies, procedures, and other submitted evidence demonstrated comprehensive provider participation and compliance programs. The compliance department delegated its SIU functions to Lexis-Nexis and delegated credentialing functions to the Denver Health and Hospital Authority (DHHA) medical staff office. The network management team described analyzing both qualitative and quantitative data such as network adequacy reports, reported referral barriers, and grievance and appeal trends to determine if gaps in the network existed. If gaps were identified, DHMP would then target recruiting efforts. The Enterprise Compliance Services (ECS) program presented well-developed procedures that articulated DHMP's commitment to comply with federal, State, and contract requirements related to detecting and preventing fraud, waste, and abuse. Onboarding and annual trainings were required for all staff members, and during the interviews, staff members described in-person, individualized trainings that were conducted for board members. Policies described training expectations, which included maintenance of medical licenses, certifications in healthcare compliance, and internal audit processes.

The credentialing department maintained detailed policies and procedures based on NCQA and Council for Affordable Quality Healthcare (CAQH) credentialing standards and maintained oversight through a bimonthly credentialing committee. DHMP documented and reviewed necessary criteria for credentialing and recredentialing, including verification sources, decision-making procedures, and file management systems. Sample record reviews demonstrated timely attestation, verification, recredentialing, and site surveys (as applicable) completed with 100 percent compliance.

Delegation policies described pre-delegation evaluation and initial and ongoing delegate monitoring activities. The contract template included many components of the required federal and State regulations. DHMP submitted evidence of monitoring delegated activities for a sample of the delegated entities; this evidence included annual audits, monitoring reports, and regular meetings with agendas and minutes.

The quality management, credentialing, pharmacy and therapeutics, compliance, ambulatory, network management, medical management, operations management, patient safety, and physician executive committees worked together to support monitoring functions outlined in the QAPI program. For each committee and leadership role, goals and responsibilities were clearly described. DHMP evaluated the QAPI program annually, as evidenced by the submitted reports. QAPI evaluations contained extensive qualitative and quantitative documentation of successes and follow-up action plans. DHMP's HIS was able to effectively collect, analyze, integrate, and report key data.

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

The compliance of the delegation subcontracts reviewed varied substantially across contracts. While the new contract template submitted for DHMP's Medicaid program included all required provisions, three of the subcontracts reviewed as part of the sample chosen did not. DHMP was required to revise the subcontracts to include all required provisions (i.e., the right to audit for 10 years; the right to audit by CMS, HHS-OIG, or other designees; and documents to be made available to the State and CMS or designees).

Although DHMP's HIS provided information on utilization, encounters, claims, grievances, and appeals, DHMP staff members were not able to describe a procedure for monitoring disenrollment for reasons other than the loss of Medicaid eligibility. DHMP was required to develop a mechanism to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.

Validation of Network Adequacy

DHMP: Strengths

DHMP participated in all quarterly network adequacy reporting. While DHMP did not meet all minimum time and distance requirements across all counties in each county designation, DHMP's NAV report includes the MCO's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, DHMP should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—DHMP 412 Audit Over-Read

FY 2020–2021 was DHMP's sixth year participating in the independent MCO EDV and subsequent over-read. DHMP validated 103 cases from each of four service categories. Table 3-70 presents DHMP's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-70—Self-Reported EDV Results by Data Element and Service Category for DHMP

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	94.2%	98.1%	86.4%	100%
Through Date	94.2%	NA	NA	NA
Diagnosis Code	91.3%	94.2%	68.9%	84.5%

Data Element	Inpatient	Outpatient	Professional	FQHC
Surgical Procedure Code	95.1%	NA	NA	NA
Procedure Code	NA	87.4%	78.9%	76.7%
Procedure Code Modifier	NA	97.1%	78.9%	98.1%
Discharge Status	93.2%	NA	NA	NA
Units	NA	97.1%	84.5%	94.2%

NA indicates that a data element was not evaluated for the specified service category.

DHMP provided medical record documentation for all sampled over-read cases. Table 3-71 presents DHMP's FY 2020–2021 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 73 of the 80 sampled encounters, resulting in a 91.3 percent agreement rate. The overall agreement rate was slightly lower than the 96.3 percent overall agreement rate from the FY 2019–2020 EDV.

Table 3-71—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for DHMP

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Over-Read Cases	Percentage With Complete Agreement	Total Number of Over-Read Elements	Percentage With Complete Agreement
Inpatient	20	100%	120	100%
Outpatient	20	90.0%	100	97.0%
Professional	20	100%	100	100%
FQHC	20	75.0%	100	95.0%
Total	**80**	**91.3%**	**420**	**98.1%**

DHMP: Strengths

Overall results continue to show relatively strong agreement between DHMP and HSAG reviewers year over year. DHMP self-reported high accuracy scores for inpatient services, reaching above 90 percent accuracy for all encounter data types, and HSAG noting 100 percent agreement for validated data elements.

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

The high level of over-read agreement and the well-documented EDV combined with the varying service coding accuracy rates support the conclusion that DHMP has targeted opportunities to improve its encounter data quality among professional and FQHC services. This points to the completeness, accuracy, and timeliness of encounter data as potential targets for root cause analysis. As such, HSAG suggests that DHMP consider internal data monitoring and provider training to improve medical record documentation.

CAHPS Survey

Table 3-72 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2018–2019 through FY 2020–2021.

Table 3-72—Adult Medicaid Top-Box Scores for DHMP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score
Getting Needed Care	71.8%	74.5%	84.1% ▲
Getting Care Quickly	74.7%	73.5%	79.9%
How Well Doctors Communicate	92.0%	94.2%	94.2%
Customer Service	90.0%+	89.1%+	91.5%
Rating of Personal Doctor	66.0%	69.6%	77.7% ↑
Rating of Specialist Seen Most Often	70.7%+	74.1%+	63.2%
Rating of All Health Care	50.3%	55.5%	58.1%
Rating of Health Plan	56.4%	60.3%	58.0%

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

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*
↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*
▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

DHMP: Adult Medicaid Strengths

For the adult Medicaid population, DHMP scored statistically significantly higher in FY 2020–2021 than in FY 2019–2020 on one measure, *Getting Needed Care*. The *Getting Needed* Care measure also improved over a three-year period. In addition, DHMP scored statistically significantly higher than the 2020 NCQA national average on one measure, *Rating of Personal Doctor*.

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

For the adult Medicaid population, HSAG found that two measures scored lower in FY 2020–2021 than in FY 2019–2020 (*Rating of Specialist Seen Most Often* and *Rating of Health Plan*), although were not statistically significantly lower. In addition, HSAG found that three measures scored lower than the 2020 NCQA national average (*Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*), although none were statistically significantly lower. HSAG recommends that DHMP further explore members' perceptions regarding the health plan overall and members' access to care and timeliness of receiving care and services to determine what could be driving lower scores compared to national averages. Although getting care quickly may be related to potential access to care issues, all of these measures are related to the quality domain. To impact the quality domain, HSAG recommends

enhancing provider informational materials and exploring providers' ability to communicate effectively with members. HSAG also recommends enhancing or developing more frequent communications with members such as member newsletters and condition management materials.

CAHPS measures have become an invaluable evaluation tool used to gauge performance; therefore, DHMP should continue to collect and monitor these data and compare to national Medicaid benchmarks. HSAG recommends that DHMP focus on identifying and implementing strategies to improve performance, particularly for measures that did not meet the 2020 NCQA national average.

Table 3-73 shows the child Medicaid CAHPS results achieved by DHMP for FY 2018–2019 through FY 2020–2021.

Table 3-73—Child Medicaid Top-Box Scores for DHMP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score
Getting Needed Care	78.2%	75.1%+	84.8%+
Getting Care Quickly	87.2%	80.5%+	89.0%+
How Well Doctors Communicate	95.5%	94.9%+	96.3%+
Customer Service	86.1%+	89.0%+	91.3%+
Rating of Personal Doctor	85.9%	78.8%	80.6%
Rating of Specialist Seen Most Often	75.7%+	60.9%+	80.8%+
Rating of All Health Care	73.5%	66.0%+	76.5%+
Rating of Health Plan	73.2%	67.4%	68.4%

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 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

DHMP: Child Medicaid Strengths

For the child Medicaid population, HSAG found that all measures scored higher in FY 2020–2021 than in FY 2019–2020, although none were statistically significantly higher. In addition, HSAG found that five measures scored higher than the 2020 NCQA national average (*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Customer Service*, and *How Well Doctors Communicate*), although none were statistically significantly higher. The *Customer Service* measure had a three-year improvement. Additionally, the *Rating of Specialist Seen Most Often* measure showed a 19.9 percentage point increase from FY 2019–2020 to FY 2020–2021.

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

For the child Medicaid population, HSAG found that three measures scored lower than the 2020 NCQA national average (*Getting Needed Care*, *Getting Care Quickly*, and *Rating of Health Plan*), although none were statistically significantly lower. HSAG recommends that DHMP further explore parents'/caretakers' perceptions regarding the health plan overall and the child members' access to care and timeliness of receiving care and services to determine what could be driving lower scores compared to national averages. To impact the quality domain, HSAG recommends enhancing provider informational materials and exploring providers' ability to communicate effectively with members. HSAG also recommends enhancing or developing more frequent communications with members such as member newsletters and condition management materials.

CAHPS measures have become an invaluable evaluation tool used to gauge performance; therefore, DHMP should continue to collect and monitor these data and compare to national Medicaid benchmarks. HSAG recommends that DHMP focus on identifying and implementing strategies to improve performance, particularly for measures that did not meet the 2020 NCQA national average.

Rocky Mountain Health Plans Medicaid Prime

Validation of RMHP Prime's Performance Improvement Project

Validation Activities and Interventions

Table 3-74 and Table 3-75 display the FY 2020–2021 validation findings for RMHP Prime's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, RMHP Prime completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, RMHP Prime defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim statements. The SMART Aim statements that RMHP Prime defined for the two PIP outcome measures in Module 1 are provided in Table 3-74.

Table 3-74—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.3% to 20.0%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 33.3% to 46.89%.

In Module 2—Intervention Determination, RMHP Prime conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, RMHP Prime updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by RMHP Prime in Module 2 are summarized for the two PIP outcome measures in Table 3-75. The PIP had not progressed to the point of deploying and testing interventions. The interventions that RMHP Prime ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-75—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Established workflow for depression screening during office visits. • Established workflow for depression screening during telehealth visits. • Provider awareness and understanding of appropriate depression screening coding practices.
Potential Interventions	• Implement provider and office staff education on depression screening workflow for office visits. • Establish a workflow for depression screening during telehealth visits. • Implement provider training on depression screening scoring, documentation, and reporting.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Established workflow for patient follow-up care following a positive depression screen. • Registry of patients who screen positive for depression. • Effective utilization of behavioral health specialists. • Consistent scheduling and billing for follow-up visits.
Potential Interventions	• Establish processes and workflows to define appropriate care when a patient screens positive for depression. • Develop registry of patients who screen positive for depression to support appropriate behavioral health follow-up. • Expand utilization of telehealth services to provide follow-up behavioral services.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, RMHP Prime will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. RMHP Prime will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

RMHP Prime: Strengths

The validation findings suggest that RMHP Prime was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. RMHP Prime also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential

interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Depression Screening and Follow-Up After a Positive Depression Screen PIP

As RMHP Prime continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- RMHP Prime should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as RMHP Prime progresses through determining and testing interventions.
- RMHP Prime should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, RMHP Prime should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

HEDIS Measure Rates and Validation

RMHP Prime: Information Systems Standards Review

According to the HEDIS MY 2020 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 3-76 shows the performance measure results for RMHP Prime for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile ranking for each HEDIS MY 2020 rate.

Table 3-76—Performance Measure Results for RMHP Prime

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 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)	54.29%	NA	NA	—
Combination 2 (Meningococcal, Tdap, HPV)	14.29%	NA	NA	—
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	NA	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	NA	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	19.40%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	4.37%	5.86%	5.83%	<10th
Counseling for Nutrition—Total	15.53%	20.08%	20.42%	<10th
Counseling for Physical Activity—Total	0.00%	1.26%	0.00%	<10th
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	42.00%	56.65%^	<10th
Postpartum Care	—	35.92%	32.89%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	71.84%	72.10%	69.54%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Total	46.46%	47.77%	45.03%	10th–24th
Breast Cancer Screening[1]				
Breast Cancer Screening	50.10%	48.04%	**44.82%^^**	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Cervical Cancer Screening[1]				
Cervical Cancer Screening	41.93%	39.39%	40.27%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	2.86%	2.00%	1.24%	10th–24th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.20%	73.71%	**55.45%^^**	50th–74th
Effective Continuation Phase Treatment	33.85%	64.85%	**42.47%^^**	50th–74th
Follow-Up Care for Children Prescribed ADHD Medication[1]				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	43.33%	62.50%	75th–89th
Cholesterol Testing—Total	—	26.67%	34.38%	25th–49th
Blood Glucose and Cholesterol Testing—Total	20.00%	26.67%	34.38%	25th–49th
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[1]	84.59%	84.59%	86.61%	25th–49th
*HbA1c Poor Control (>9.0%)**[,1]	76.08%	76.08%	71.37%^	<10th
HbA1c Control (<8.0%)[1]	19.55%	19.55%	23.85%^	<10th
Eye Exam (Retinal) Performed[1]	50.14%	50.14%	48.57%	10th–24th
Blood Pressure Control (<140/90 mm Hg)[2]	—	—	0.13%	—
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	46.70%	43.04%	49.29%^	<10th
Statin Adherence 80%	60.05%	85.57%	**70.39%^^**	75th–89th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	64.86%	57.44%	61.69%	<10th
Statin Adherence 80%—Total	60.83%	92.86%	**85.09%^^**	≥90th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	71.67%	72.76%	75.88%	50th–74th
Pharmacotherapy Management of COPD Exacerbation[1]				
Systemic Corticosteroid	40.28%	37.33%	50.64%^	<10th
Bronchodilator	56.48%	54.22%	67.66%^	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Asthma Medication Ratio				
Total	53.74%	48.40%	51.78%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.09%	29.46%	25.87%	25th–49th
Antibiotic Stewardship				
Appropriate Testing for Pharyngitis[1]				
Total	—	73.66%	78.95%^	50th–74th
Appropriate Treatment for Upper Respiratory Infection				
Total	—	88.24%	87.28%	25th–49th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Total	—	47.83%	49.12%	25th–49th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.64	0.65	1.02	10th–24th
Average Days Supplied per Antibiotic Script—Total	9.11	18.21	9.52	25th–49th
Average Scripts PMPY for Antibiotics of Concern—Total	0.25	0.25	0.37	25th–49th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	39.52%	38.88%	36.51%	50th–74th
Opioids				
Use of Opioids at High Dosage*[1]				
Use of Opioids at High Dosage	—	8.84%	9.89%	10th–24th
Use of Opioids From Multiple Providers*[1]				
Multiple Pharmacies	4.22%	1.91%	1.53%	≥90th
Multiple Prescribers	25.73%	57.73%	14.92%^	75th–89th
Multiple Prescribers and Multiple Pharmacies	2.79%	1.91%	0.66%	≥90th
Risk of Continued Opioid Use*[1]				
At Least 15 Days Covered—Total	—	13.01%	13.61%	<10th
At Least 31 Days Covered—Total	—	4.25%	6.78%	<10th
Pharmacotherapy for Opioid Use Disorder[1]				
Total	—	54.02%	**42.15%^^**	75th–89th
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	61.52	60.25	49.02	50th–74th
Outpatient Visits—Total	326.38	341.87	304.91	10th–24th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	9.42	9.96	8.86	75th–89th
Total Average Length of Stay (Total Inpatient)	3.68	4.27	4.23	25th–49th
Total Discharges per 1,000 Member Months (Medicine)	4.39	4.65	4.10	75th–89th
Total Average Length of Stay (Medicine)	3.74	4.00	4.15	50th–74th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Surgery)	2.23	2.57	2.29	75th–89th
Total Average Length of Stay (Surgery)	5.26	6.81	6.51	10th–24th
Total Discharges per 1,000 Member Months (Maternity)	2.96	2.93	2.66	25th–49th
Total Average Length of Stay (Maternity)	2.33	2.35	2.22	<10th
Plan All-Cause Readmissions*				
Observed Readmissions—Total	—	9.87%	9.34%	50th–74th
O/E Ratio—Total	—	1.02	0.93	50th–74th

**For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 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 MY 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 MY 2018 or HEDIS MY 2019.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

RMHP Prime: Strengths

The following HEDIS MY 2020 measure rates were determined to be high-performing rates for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2019):

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Appropriate Testing for Pharyngitis—Total*
- *Use of Opioids From Multiple Providers—Multiple Pharmacies*, *Multiple Prescribers*, and *Multiple Prescribers and Multiple Pharmacies*

For HEDIS MY 2020, RMHP Prime demonstrated strength with measures related to members who received opioids from four or more different prescribers and pharmacies during the measurement year, as evidenced by rates for *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* exceeding the 90th percentile, and the rate for *Use of Opioids From Multiple Providers—Multiple Prescribers* demonstrating statistically significant improvement and measuring at or above the 75th percentile. For this measure, lower rates indicate better performance.

Additionally, RMHP Prime's rate for *Appropriate Testing for Pharyngitis—Total* showed statistically significant improvement from the previous year and ranked at or above the 50th percentile. RMHP Prime's rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose*

Testing—Total was at or above the 75th percentile, exhibiting strength for the number of members who had two or more antipsychotic medication prescriptions and received blood glucose testing.

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

The following HEDIS MY 2020 measure rates were determined to be low-performing rates 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 MY 2019):

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Prenatal and Postpartum Care—Postpartum Care*
- *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*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total*
- *Asthma Medication Ratio—Total*
- *Use of Opioids at High Dosage*
- *Risk of Continued Opioid Use—At Least 15 Days Covered—Total* and *At Least 31 Days Covered—Total*

For HEDIS MY 2020, RMHP Prime demonstrated opportunities to improve rates within the Pediatric Care, Access to Care, and Preventive Screening domains falling below the 25th percentile. The MCO should work with the Department and providers to identify the causes for the low access to care and preventive screening rates (e.g., barriers to care, lack of family planning services, provider training, community outreach and education) and implement strategies to improve care for members.

Additionally, RMHP Prime's performance related to appropriately prescribing medications and monitoring members with chronic conditions (e.g., diabetes, cardiovascular disease, 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 care for members with chronic conditions or chronic pain.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Prime Overall Evaluation

Table 3-77 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 2020–2021.

Table 3-77—Summary of RMHP Prime Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	15	1	0	0	94%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Standard X—Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**67**	**2**	**0**	**0**	**97%***

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

Table 3-78 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 2020–2021.

Table 3-78—Summary of RMHP Prime Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)*
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**166**	**166**	**0**	**24**	**100%****

**RMHP Credentialing record review scores are based on a combined score for RMHP (Region 1) and Prime.*

***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: Trended Performance for Compliance With Regulations

Table 3-79—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 (Includes Confidentiality) (2015–2016, 2018–2019)	80%	86%
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 (Selection) and Program Integrity (2017–2018, 2020–2021)	**93%**	**94%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2020–2021)	**100%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**100%**	**75%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2020–2021)	**100%**	**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 2020–2021.

Trended scores across review cycles demonstrate that RMHP Prime maintained 100 percent compliance scores for Standard VIII—Credentialing and Recredentialing and Standard X—Quality Assessment and Performance Improvement, and improved by one percentage point for Standard VII—Provider Participation (Selection) and Program Integrity. Although it appears compliance decreased substantially (by 10 or more percentage points) for Standard IX—Subcontractual Relationships and Delegation, HSAG notes that this standard includes only four requirements, which skews results if the health plan has one sample contract that does not contain updated language required by the 2016 Medicaid regulation revisions.

HSAG recommends that RMHP Prime continue efforts to maintain full compliance with regulations as demonstrated in previous review cycles and focus on coming into compliance for standards scoring below 90 percent compliance, with particular consideration to the four lowest scoring standards: Standard IX—Subcontractual Relationships and Delegation, Standard V—Member Information, Standard VI—Grievance and Appeal Systems, and Standard IV—Member Rights and Protections (Includes Confidentiality).

RMHP Prime: Strengths

RMHP Prime submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, and sample documents. Documents illustrated a thorough and comprehensive approach to complying with regulations.

RMHP Prime maintained a well-established provider network that appeared to be sufficient to meet the needs of its members. Staff members described how the provider network is monitored and the process that occurs when gaps in the network are identified. RMHP Prime maintained provider participation through numerous approaches, including by identifying service gaps, rewarding high performance providers through reimbursement strategies, and attending community events in which RMHP Prime hosted informational sessions that outlined the contracting process.

RMHP Prime demonstrated a robust program integrity system through a compliance program description and associated policies and procedures, which identified the compliance officer and compliance committee, and defined oversight of the program. The compliance committee provided oversight of compliance-related activities by reviewing risk assessments and assigning priorities based on compliance and/or business risks.

RMHP Prime's credentialing and recredentialing process was clearly explained through procedures and followed NCQA credentialing standards. HSAG completed a review of initial and recredentialing sample files for individual providers; RMHP Prime achieved 100 percent compliance with all required elements.

Most delegated activities were related to credentialing and recredentialing; other delegated functions included pharmacy benefit management, behavioral health services, and UM. RMHP Prime maintained a comprehensive set of documents that reflected ongoing reporting and oversight activities, which included annual credentialing delegation audit reports. The department associated with the delegated function provided oversight, and monitoring activities were described in a delegation policy for each functional area.

RMHP Prime maintained a well-developed, thorough, and continuous QAPI program as evidenced by the Annual Evaluation/Quality Assessment document, the Annual Evaluation Quality report, and the QI workplan. Documents contained informative summaries; data analysis; reflected successes; ongoing opportunities; identified and analyzed barriers; delineated councils and committee functions; and outlined the frequency of monitoring and review of data, performance, and successes.

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

Although RMHP Prime's policies and procedures provided information regarding member liability for covered services, HSAG noted areas within the provider manual that did not contain entirely accurate information for specific lines of business (CHP+, RAE, and RMHP Prime). RMHP Prime was required

to revise the member liability language in the provider manual to accurately address the various lines of business that may have variations in copays and member financial responsibilities.

Some of the sample delegated credentialing agreements failed to include the required language regarding the right to audit by the HHS-OIG, Comptroller General, or other designees, and that records must be retained for up to 10 years. RMHP Prime was required to update the delegates' credentialing agreements to include the required provisions.

Validation of Network Adequacy

RMHP Prime: Strengths

RMHP Prime participated in all quarterly network adequacy reporting. While RMHP Prime did not meet all minimum time and distance requirements across all counties in each county designation, RMHP Prime's NAV report includes the MCO's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

To support accurate network information that facilitates members' access to care, RMHP Prime should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

Encounter Data Validation—RMHP Prime 412 Audit Over-Read

FY 2020–2021 was RMHP Prime's third year participating in the independent MCO EDV and subsequent over-read. RMHP Prime validated 103 cases from each of four service categories; Table 3-80 presents RMHP Prime's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-80—Self-Reported EDV Results by Data Element and Service Category for RMHP Prime

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	87.4%	89.3%	80.6%	96.1%
Through Date	86.4%	NA	NA	NA
Primary Diagnosis Code	75.7%	85.4%	71.8%	55.3%
Primary Surgical Procedure Code	57.3%	NA	NA	NA
Discharge Status	77.7%	NA	NA	NA
Procedure Code	NA	88.3%	76.7%	93.2%
Procedure Code Modifier	NA	88.3%	72.8%	85.4%
Units	NA	87.4%	76.7%	96.1%

NA indicates that a data element was not evaluated for the specified service category.

RMHP Prime provided medical record documentation for all sampled over-read cases; Table 3-81 presents RMHP Prime's FY 2020–2021 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 67 of the 80 sampled encounters, resulting in an 83.8 percent agreement rate. The overall agreement rate was slightly lower than the 87.5 percent overall agreement rate from the FY 2019–2020 EDV.

Table 3-81—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for RMHP Prime

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Over-Read Cases	Percentage With Complete Agreement	Total Number of Over-Read Elements	Percentage With Complete Agreement
Inpatient	20	85%	120	95%
Outpatient	20	80%	100	93%
Professional	20	100%	100	100%
FQHC	20	70%	100	91%
Total	**80**	**83.8%**	**420**	**94.8%**

RMHP Prime: Strengths

Overall results continue to show moderately strong agreement between RMHP Prime and HSAG reviewers year over year. RMHP Prime self-reported moderate accuracy scores for inpatient, outpatient and professional services, with slightly higher scores for services rendered in FQHCs. HSAG noted 100 percent agreement with professional service over-read cases.

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

RMHP Prime's service coding accuracy results show an accuracy rate of 57.3 percent for the *Primary Surgical Procedure Code* data element among inpatient cases and an accuracy rate of 55.3 percent for the *Primary Diagnosis Code* data element among FQHC cases. When examining RMHP Prime's self-reported service coding accuracy rates among each data element (i.e., a total of 20 data elements across the encounter types), RMHP Prime reported rates less than 80.0 percent for eight data elements. The high level of over-read agreement and the well-documented EDV combined with RMHP Prime's low service coding accuracy rates support the conclusion that RMHP Prime has opportunities to improve its encounter data quality. This points to the completeness, accuracy, and timeliness of encounter data as potential targets for root cause analysis.

CAHPS Survey

Table 3-82 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2018–2019 through FY 2020–2021.

Table 3-82—Adult Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score
Getting Needed Care	84.2%	84.5%	83.5%
Getting Care Quickly	82.6%	83.1%	80.2%+
How Well Doctors Communicate	95.1%	93.4%	92.1%
Customer Service	93.8%+	94.7%+	89.7%+
Rating of Personal Doctor	74.4%	75.1%	67.9%
Rating of Specialist Seen Most Often	69.6%	66.7%+	69.7%+
Rating of All Health Care	64.3%	58.6%	53.9%
Rating of Health Plan	69.1%	68.3%	55.1% ↓ ▼

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.

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*
↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*
▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

RMHP Prime: Adult Medicaid Strengths

For the adult Medicaid population, HSAG found that one measure, *Rating of Specialist Seen Most Often*, scored higher in FY 2020–2021 than in FY 2019–2020, although it was not statistically significantly higher. In addition, HSAG found that one measure, *Customer Service*, scored higher than the 2020 NCQA national average, although it was not statistically significantly higher.

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

For the adult Medicaid population, HSAG found that all measures, except for *Rating of Specialist Seen Most Often*, scored lower in FY 2020–2021 than in FY 2019–2020. In addition, RMHP Prime scored statistically significantly lower in FY 2020–2021 than in FY 2019–2020 and statistically significantly lower than the 2020 NCQA national average on one measure, *Rating of Health Plan*. HSAG recommends that RMHP Prime further explore factors that drive member perceptions regarding those measures. The *Getting Care Quickly* measure showed a decline in score during the past three years. HSAG recommends that RMHP Prime evaluate more closely the factors that drive member perception regarding access to care.

CAHPS measures have become an invaluable evaluation tool used to gauge performance; therefore, RMHP Prime should continue to collect and monitor these data and compare to national Medicaid benchmarks. HSAG recommends that RMHP Prime focus on identifying and implementing strategies to improve performance, particularly for measures that did not meet the 2020 NCQA national average.

Table 3-83 shows the child Medicaid CAHPS results achieved by RMHP Prime for FY 2018–2019 through FY 2020–2021.

Table 3-83—Child Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score
Getting Needed Care	91.5%+	NA	86.3%
Getting Care Quickly	88.4%+	NA	91.1%
How Well Doctors Communicate	89.6%+	NA	97.4% ↑
Customer Service	85.7%+	NA	89.3%+
Rating of Personal Doctor	71.7%+	NA	75.0%
Rating of Specialist Seen Most Often	75.0%+	NA	73.0%+
Rating of All Health Care	68.8%+	NA	74.7%
Rating of Health Plan	71.4%+	NA	69.9%

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.

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.

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*
↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

RMHP Prime: Child Medicaid Strengths

For the child Medicaid population, RMHP Prime scored statistically significantly higher than the 2020 NCQA national average on one measure, *How Well Doctors Communicate*. RMHP Prime's scores were higher in FY 2020–2021 compared to FY 2018–2019 for five out of eight measures.

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

For the child Medicaid population, HSAG found that three measures scored lower than the 2020 NCQA national average (*Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*), although none were statistically significantly lower. HSAG recommends that RMHP Prime further explore parents'/caretakers' perceptions regarding their child's health plan overall, their child's personal doctor, and their child's specialist to determine what could be driving lower scores compared to national averages.

CAHPS measures have become an invaluable evaluation tool used to gauge performance; therefore, RMHP Prime should continue to collect and monitor these data and compare to national Medicaid benchmarks. HSAG recommends that RMHP Prime focus on identifying and implementing strategies to improve performance, particularly for measures that did not meet the 2020 NCQA national average.

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Statewide Results

Table 4-1 shows the FY 2020–2021 statewide PIP results for the RAEs and the MCOs.

Table 4-1—FY 2020–2021 Statewide PIP Results

Health Plan	PIP Topic	Module Status	Validation Status*
Region 1—RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 2—NHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 3—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 4—HCI	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 5—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 6—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
Region 7—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA
RMHP Prime	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1 and Module 2*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2020–2021 validation cycle.*

During FY 2020–2021, the health plans initiated new rapid-cycle PIPs focusing on *Depression Screening and Follow-Up After a Positive Depression Screen*, a statewide topic selected by the Department. The PIPs run on an 18-month schedule and will continue into the next fiscal year. The PIPs will be evaluated on outcomes and receive a final validation status after the health plans complete all four modules of the rapid-cycle PIP process and submit final documentation for validation.

During the FY 2020–2021 validation cycle, the health plans received training and technical assistance on the rapid-cycle PIP process and developed the foundation of the projects in the first two modules of the process. The health plans submitted documentation on Module 1 and Module 2 for a total of nine PIPs. HSAG provided feedback to the health plans on the initial submissions, and the health plans revised the module documentation and resubmitted Module 1 and Module 2 until all criteria were achieved. The health plans passed Module 1 and Module 2, achieving all validation criteria for the first two modules for all nine PIPs.

Statewide Conclusions and Recommendations Related to Validation of PIPs

The FY 2020–2021 validation findings for all nine PIPs suggested that all health plans designed methodologically sound projects addressing the Department-selected statewide rapid-cycle PIP topic. The health plans used data to identify a narrowed focus for each project, convened PIP teams to include necessary internal and external partners, established a goal for improvement, and defined a measure and data collection plan to evaluate progress toward achieving the goal. In the next fiscal year, the health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. As the health plans continue working on the PIPs, HSAG recommends the following:

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

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 4-2, health plan-specific and statewide weighted averages are presented for the seven RAEs for FY 2020–2021. Cells shaded green indicate performance met or exceeded the FY 2019–2020 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 4-2—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 RAE Average
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	41.72%	42.34%	38.84%	38.98%	31.19%	35.29%	46.37%	38.84%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	47.66%	74.23%	64.71%	79.61%	71.20%	73.69%	77.93%	68.71%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	30.85%	39.25%	31.97%	43.83%	37.85%	37.42%	35.41%	36.02%

Performance Measure	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	Statewide RAE Average
Follow-Up After a Positive Depression Screen	51.47%	53.25%	41.50%	42.87%	34.64%	45.87%	61.75%	51.94%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.57%	23.00%	12.17%	27.78%	23.70%	20.79%	21.51%	19.99%

Cells shaded green indicate the rate met or exceeded the FY 2019–2020 goal.

Statewide Conclusions and Recommendations

During this measurement period, none of the statewide averages met the goal. Additionally, only one RAE, HCI, exceeded the goal for any measure, which was *Behavioral Health Screening or Assessment for Children in the Foster Care System*.

HSAG recommends that the RAEs should 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—MCOs

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 4-3, health plan-specific and Colorado Medicaid weighted averages are presented for the MCOs for HEDIS MY 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 4-3—MCO and Statewide Results

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	83.36%	56.65%	70.45%
Postpartum Care	69.22%	32.89%	51.65%
Adults' Access to Preventive/Ambulatory Health Services			
Total	51.52%	69.54%	59.08%
Preventive Screening			
Chlamydia Screening in Women			
Total	67.35%	45.03%	60.19%
Breast Cancer Screening			
Breast Cancer Screening	42.60%	44.82%	43.82%
Cervical Cancer Screening			
Cervical Cancer Screening	41.11%	40.27%	40.72%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	1.24%	0.11%
Mental/Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	61.14%	55.45%	58.08%
Effective Continuation Phase Treatment	40.73%	42.47%	41.66%
Living With Illness			
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	76.47%
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	73.18%	86.61%	79.55%
*HbA1c Poor Control (>9.0%)**	52.46%	71.37%	61.43%
HbA1c Control (<8.0%)	38.41%	23.85%	31.50%
Eye Exam (Retinal) Performed	36.25%	48.57%	42.09%
Blood Pressure Control (<140/90 mm Hg)	50.23%	0.13%	26.46%
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	60.67%	49.29%	55.10%
Statin Adherence 80%	67.46%	70.39%	68.74%
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	73.66%	61.69%	66.67%
Statin Adherence 80%—Total	67.88%	85.09%	77.18%
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	80.29%	75.88%	78.17%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	50.21%	50.64%	50.42%
Bronchodilator	65.02%	67.66%	66.32%
Asthma Medication Ratio			
Total	51.41%	51.78%	51.56%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.00%	25.87%	27.70%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Antibiotic Stewardship			
Appropriate Testing for Pharyngitis			
Total	80.37%	78.95%	79.81%
Appropriate Treatment for Upper Respiratory Infection			
Total	97.50%	87.28%	94.92%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	82.92%	49.12%	67.31%
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics—Total	0.28	1.02	0.50
Average Days Supplied per Antibiotic Script—Total	9.72	9.52	9.60
Average Scripts PMPY for Antibiotics of Concern—Total	0.08	0.37	0.17
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	29.13%	36.51%	33.64%
Opioids			
Use of Opioids at High Dosage*			
Use of Opioids at High Dosage	4.40%	9.89%	7.64%
Use of Opioids From Multiple Providers*			
Multiple Pharmacies	4.34%	1.53%	2.66%
Multiple Prescribers	14.92%	14.92%	14.92%
Multiple Prescribers and Multiple Pharmacies	3.28%	0.66%	1.70%
Risk of Continued Opioid Use*			
At Least 15 Days Covered—Total	4.25%	13.61%	9.11%
At Least 31 Days Covered—Total	2.38%	6.78%	4.66%
Pharmacotherapy for Opioid Use Disorder			
Total	14.96%	42.15%	27.16%
Use of Services			
Ambulatory Care (per 1,000 Member Months)			
*Emergency Department Visits—Total**	33.75	49.02	38.36
Outpatient Visits—Total	177.62	304.91	216.06
Inpatient Utilization—General Hospital/Acute Care			
Total Discharges per 1,000 Member Months (Total Inpatient)	5.46	8.86	6.48
Total Average Length of Stay (Total Inpatient)	5.08	4.23	4.72
Total Discharges per 1,000 Member Months (Medicine)	3.25	4.10	3.50
Total Average Length of Stay (Medicine)	4.63	4.15	4.46
Total Discharges per 1,000 Member Months (Surgery)	0.99	2.29	1.39
Total Average Length of Stay (Surgery)	9.42	6.51	7.96
Total Discharges per 1,000 Member Months (Maternity)	1.58	2.66	1.95
Total Average Length of Stay (Maternity)	2.71	2.22	2.48

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Plan All-Cause Readmissions*			
Observed Readmissions—Total	11.35%	9.34%	10.45%
O/E Ratio—Total	1.14	0.93	1.05

**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 MY 2020 measure rates were determined to be high-performing rates for the MCO statewide weighted average (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2019):

- *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total*
- *Antibiotic Utilization—Average Scripts PMPY for Antibiotics of Concern—Total*, *Average Scripts PMPY for Antibiotics—Total*, and *Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total*
- *Appropriate Treatment for Upper Respiratory Infection—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Inpatient Utilization—General Hospital/Acute Care—Total Average Length of Stay (Medicine)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

The following HEDIS MY 2020 measure rates were determined to be low-performing rates for the MCO 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 MY 2019):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total*
- *Asthma Medication Ratio—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*

- *Childhood Immunization Status—Combination 2*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Inpatient Utilization—General Hospital/Acute Care—Total Discharges per 1,000 Member Months (Maternity)* and *Total Average Length of Stay (Maternity)*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

Based on performance measure results, HSAG recommends that the Department and the MCOs evaluate some of the ongoing interventions that they have established. For example, both MCOs created interventions about diabetes care specifically targeting eye exams and HbA1c control. The Department and the MCOs should determine how effective these interventions have been. Specifically, whether RMHP Prime has received any feedback on how successful its social media, phone outreach, and mailing campaigns have been, and how effective DMHP's rollout of retinal cameras in the primary care clinics has been in improving access for members and contributing to overall improvement in exam rates.

Related to substantially low performance in the Preventive Screening domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to determine how successful the interventions have been that were recently implemented. Both MCOs created interventions related to the *Breast Cancer Screening* measure. The Department and the MCOs should investigate whether any improvement has been noted since the mailing campaigns were created, and how effective RMHP Prime's Maternity and Women's Care QIC subcommittee has been in providing education to its members.

Related to low statewide scores in relation to immunizations, HSAG recommends that the Department and DHMP monitor immunizations in the SBHCs to determine how effective immunizations for children and adolescents have been in the program. Additionally, how successful the MCO's birthday postcard reminders and other mailing outreach efforts have been in reminding parents of schedule well-care visits and educating parents on what to expect during upcoming well-care visits. The COVID-19 pandemic likely had an impact on the low rates for immunizations, but other factors could have contributed as well.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

Table 4-4—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 RAE 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 (Includes Confidentiality) (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 (Selection) and Program Integrity (2020–2021)	**94%**	**94%**	**100%**	**94%**	**100%**	**100%**	**100%**	**97%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	**100%**	**94%**	**100%**	**94%**	**100%**	**100%**	**100%**	**98%**
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	**75%**	**75%**	**100%**	**75%**	**100%**	**100%**	**100%**	**89%**
Standard X—Quality Assessment and Performance Improvement (2020–2021)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

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 RAE Average
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)	100%	100%	88%	88%	88%	75%	75%	88%

Bold text indicates standards that HSAG reviewed during FY 2020–2021.

Table 4-5—Statewide Results for MCO Standards in the Most Recent Year Reviewed

Standard and Applicable Review Years	DHMP	RMHP Prime	Statewide MCO 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 (Includes Confidentiality) (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 (Selection) and Program Integrity (2020–2021)	**100%**	**94%**	**97%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	**100%**	**100%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	**75%**	**75%**	**75%**
Standard X—Quality Assessment and Performance Improvement (2020–2021)	**94%**	**100%**	**97%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)	86%	100%	93%

Bold text indicates standards that HSAG reviewed during FY 2020–2021.

Statewide Conclusions and Recommendations Related to Assessment of Compliance

For the four standards reviewed in FY 2020–2021, the Medicaid health plans demonstrated compliance in many areas. Most (five or more) Medicaid health plans statewide—both RAEs and MCOs:

- Received 100 percent compliance within the Standard X—Quality Assessment and Performance Improvement and demonstrated detailed work plans, evaluations, and methods to monitor for quality of care; analyzed over- and underutilization; ensured improved outcomes for members with special health care needs; reviewed and updated clinical practice guidelines regularly; and detailed work flows regarding the HIS requirements.

- Used a mixture of standardized software and reporting tools within the provider participation and program integrity departments alongside manual checks as a basis to ensure appropriate monitoring. Regarding program integrity, many health plans used streamlined risk assessment tools to monitor, identify, plan, and mitigate fraud, waste, and abuse. The health plans frequently developed multi-tiered compliance committees to ensure information sharing at the staff, management, and leadership levels.
- Demonstrated 100 percent compliance with all credentialing and recredentialing requirements. All health plan sample records were compliant with standards. While systems and levels of sophistication varied throughout the health plans, each maintained the ability to track providers through the application, credentialing, and onboarding process and engage the provider with regular opportunities for training and structured communications. Credentialing review committees for each health plan included a variety of specialists who were able to conduct peer reviews.
- Maintained delegation agreements with provisions that ensured ultimate accountability for delegated responsibilities remained with the health plan. Although levels of specificity varied, each health plan had means of monitoring performance through regular reporting, inter-agency meetings, and annual oversight procedures as necessary.

For Medicaid health plans statewide—both RAEs and MCOs—the most common required action assigned was the following:

- Delegate agreement language did not include the right for the HHS-OIG, Comptroller General, or other designee to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years.

Validation of Network Adequacy

Statewide Results

During FY 2020–2021, HSAG worked with the Department to update the quarterly network adequacy reporting materials and developed and deployed web-based NAV Dashboards. In preparation for the health plans' FY 2020–2021 Quarter 2 network adequacy data submissions, HSAG produced and distributed health plan-specific geoaccess compliance report templates to reduce preventable data submission errors and minimize the need for data resubmissions from the health plans.

Each quarter, HSAG validated the health plans' self-reported compliance with minimum time and distance network requirements and provided the Department with the validation results in NAV Dashboards and health plan-specific Results Briefs.

The data-related findings in this report align with HSAG's validation of the health plans' FY 2020–2021 Quarter 2 network adequacy reports, representing the measurement period reflecting the health plans' networks from October 1, 2020, through December 31, 2020.

For a RAE or MCO to be compliant with the FY 2020–2021 minimum network requirements, the health plan is required to ensure that its provider network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level). For example, all members residing in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two family practitioners. However, if members reside in counties outside their health plan's contracted geographic area, the Department does not necessarily require the health plan to meet the minimum time and distance network requirements for those members. Additionally, the health plan may have alternate methods of ensuring access to care for its enrolled members, regardless of a member's county of residence (e.g., the use of telehealth).

Health plans may have alternate methods of ensuring members' access to care (e.g., the use of telehealth).

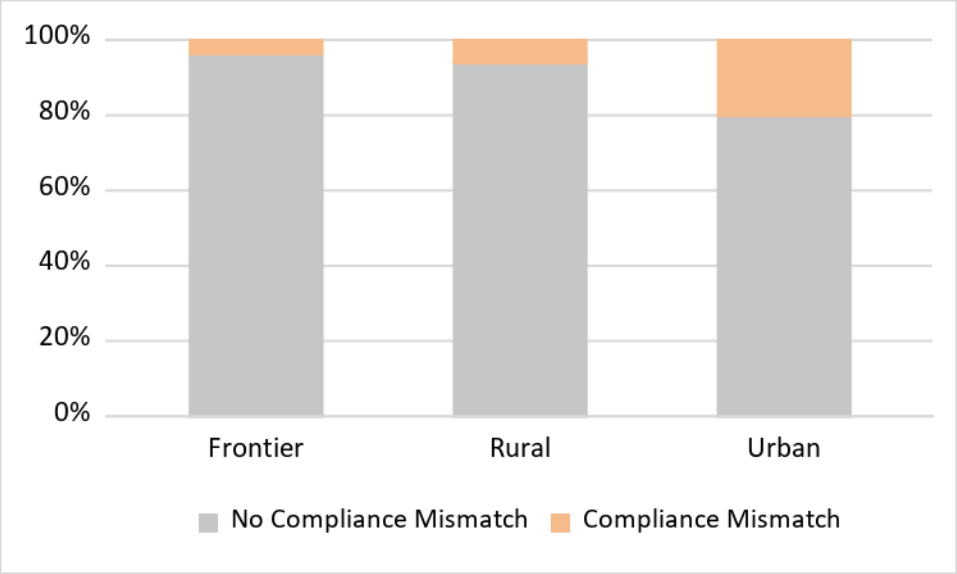
Regional Accountable Entities

This section summarizes the FY 2020–2021 NAV findings specific to the seven RAEs and DHMP. NAV results for DHMP's minimum time and distance behavioral health requirements are included in the RAEs' aggregated behavioral health results because DHMP is contracted to provide behavioral healthcare services to its members, similar to the RAEs' contractual requirements.

Compliance Match

Figure 4-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the health plans' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the health plans' quarterly geoaccess compliance results) among all RAEs by urbanicity.

Figure 4-1—Aggregate RAE Geoaccess Compliance Validation Results for FY 2020–2021 Quarter 2 by Urbanicity

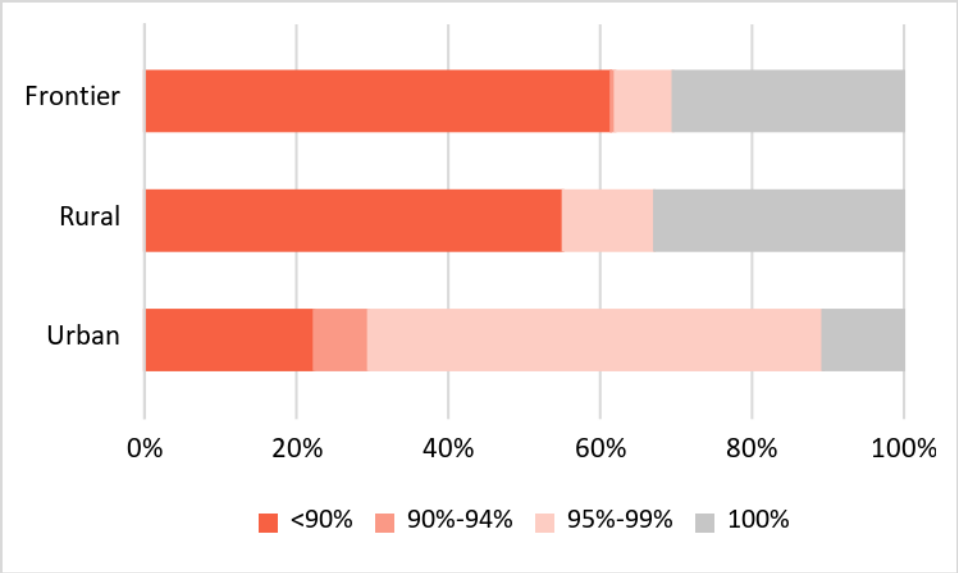


As shown in Figure 4-1, HSAG agreed with 96.2 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 93.8 percent of reported results for rural counties, and 79.8 percent of reported results for urban counties. HSAG disagreed with 3.8 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 6.2 percent of reported results for rural counties, and 20.2 percent of reported results for urban counties.

Access Level Assessment

Figure 4-2 displays the percentage of minimum time and distance physical health primary care requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of RAE members with access in the network requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-2—Percentage of Aggregate RAE Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



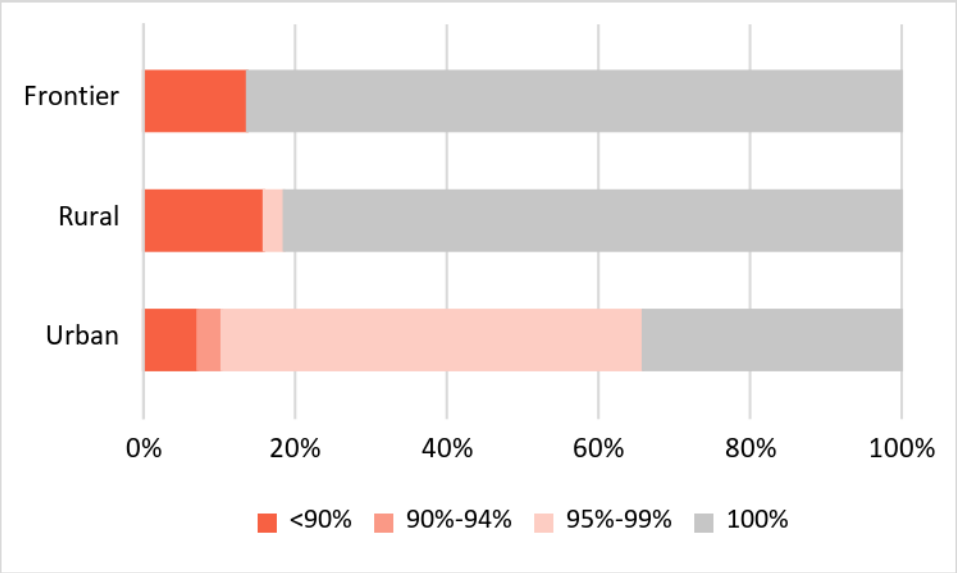
Minimum time and distance physical health primary care requirements include pediatric, adult, and family PCPs, as well as OB/GYN practitioners. RAEs are required to ensure that all members have two PCPs from each specified network type available within the specified time and distance network requirement. Since the RAEs are contracted to cover different Colorado counties, each combination of a minimum time and distance network requirement and county is measured separately.

Not all members may reside within the RAEs' contractual minimum network requirements for two or more providers in a given network category. As such, Figure 4-2 summarizes the number of physical health primary care results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The first bar in Figure 4-2 reflects a total of 184 physical health primary care results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined RAEs contracted to serve members residing in frontier counties. Of those 184 results, 30.4 percent (n=56) have 100 percent of RAE members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 8.2 percent (n=15) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 61.4 percent (n=113) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).
- The second bar in Figure 4-2 reflects a total of 216 physical health primary care results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined RAEs contracted to serve members residing in rural counties. Of those 216 RAE rural results, 32.9 percent (n=71) have 100 percent access level, 12.0 percent (n=26) of the results have 90 to 99 percent access level, and 55.1 percent (n=119) of the results have less than 90 percent access level.
- The third bar in Figure 4-2 reflects a total of 112 physical health primary care results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined RAEs contracted to serve members residing in urban counties. Of those 112 RAE urban results, 10.7 percent (n=12) have 100 percent access level, 67.0 percent (n=75) of the results have 90 to 99 percent access level, and 22.3 percent (n=25) of the results have less than 90 percent access level.

Figure 4-3 displays the percentage of minimum time and distance behavioral health requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of RAE and DHMP members with access in the network requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-3—Percentage of Aggregate RAE and DHMP Behavioral Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance behavioral health requirements include pediatric and adult psychiatrists and other psychiatric prescribers and SUD treatment practitioners and entities, as well as psychiatric hospitals or psychiatric units in acute care hospitals. The RAEs and DHMP are required to ensure that all members have two behavioral health practitioners or practice sites from each specified network type available within the specified time and distance requirement.

Not all members may reside within the RAEs' and DHMP's contractual minimum network requirements for two or more providers in a given network category. As such, Figure 4-3 summarizes the number of behavioral health results (i.e., minimum time and distance requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The top bar in Figure 4-3 reflects a total of 161 behavioral health results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined RAEs and DHMP contracted to serve members residing in frontier counties. Of those 161 results, 86.3 percent (n=139) have 100 percent of RAE and DHMP members with residential addresses in frontier counties that met the minimum network requirements (i.e., 100 percent access level). An additional 13.7 percent (n=22) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).

- The middle bar in Figure 4-3 reflects a total of 189 behavioral health results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined RAEs and DHMP contracted to serve members residing in rural counties. Of those 189 RAE and DHMP rural results, 81.5 percent (n=154) have 100 percent access level, 2.6 percent (n=5) of the results have 90 to 99 percent access level, and 15.9 percent (n=30) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-3 reflects a total of 126 behavioral health results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined RAEs and DHMP contracted to serve members residing in urban counties. Of those 126 RAE and DHMP urban results, 34.1 percent (n=43) have 100 percent access level, 58.7 percent (n=74) of the results have 90 to 99 percent access level, and 7.1 percent (n=9) of the results have less than 90 percent access level.

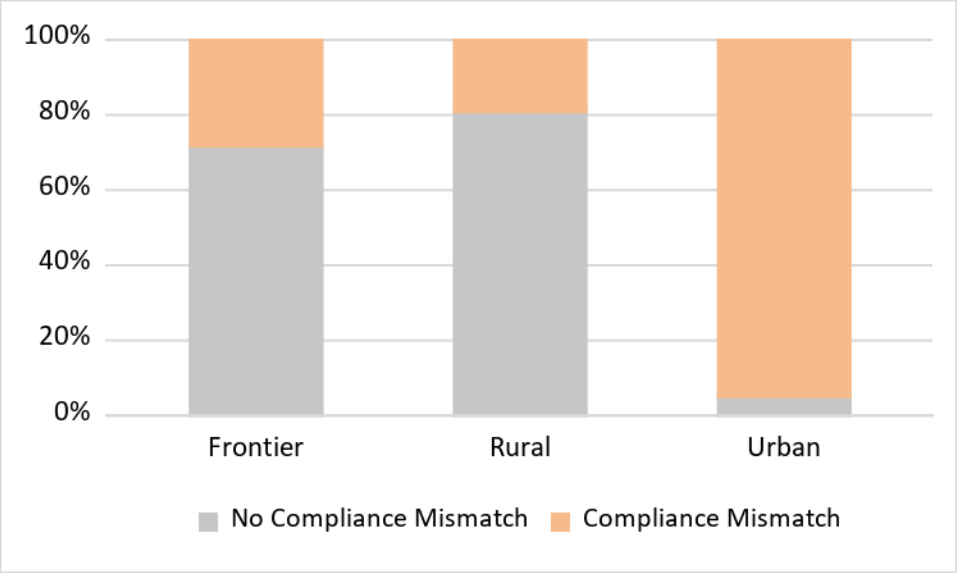
Medicaid Managed Care Organizations

This section summarizes the FY 2020–2021 NAV findings specific to the two Medicaid MCOs (DHMP and RMHP Prime). NAV results for DHMP's minimum time and distance behavioral health requirements are also included in the RAEs' aggregated behavioral health results because DHMP is contracted to provide behavioral healthcare services to its members, similar to the RAEs' contractual requirements.

Compliance Match

Figure 4-4 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCOs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCOs' quarterly geoaccess compliance results) among both MCOs by urbanicity.

Figure 4-4—Aggregate MCO Geoaccess Compliance Validation Results for FY 2020–2021 Quarter 2 by Urbanicity

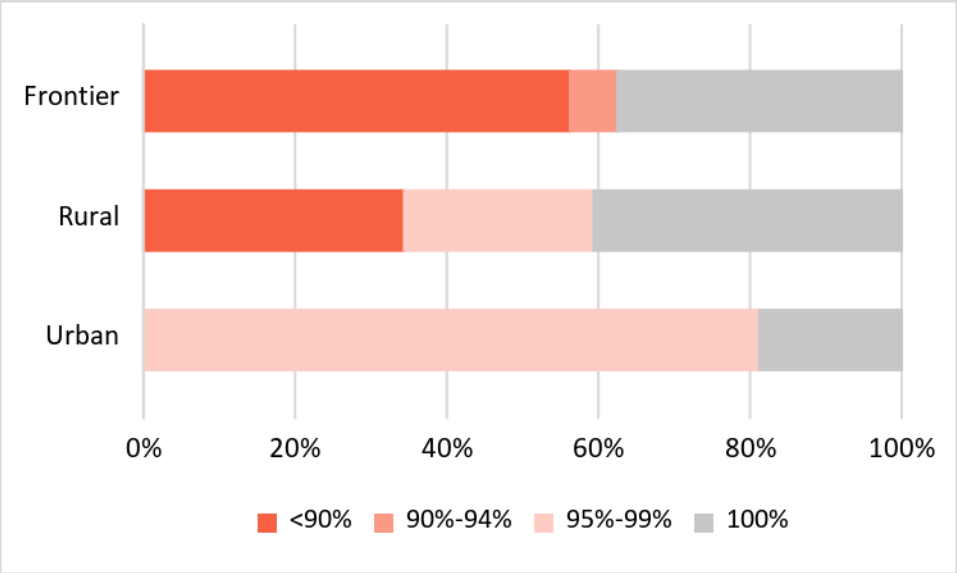


As shown in Figure 4-4, HSAG agreed with 71.7 percent of the MCOs' reported quarterly geoaccess compliance results for frontier counties, 80.8 percent of reported results for rural counties, and 5.0 percent of reported results for urban counties. HSAG disagreed with 28.3 percent of the MCOs' reported quarterly geoaccess compliance results for frontier counties, 19.2 percent of reported results for rural counties, and 95.0 percent of reported results for urban counties.

Access Level Assessment

Figure 4-5 displays the percentage of physical health primary care requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of MCO members with access in the requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-5—Percentage of Aggregate MCO Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



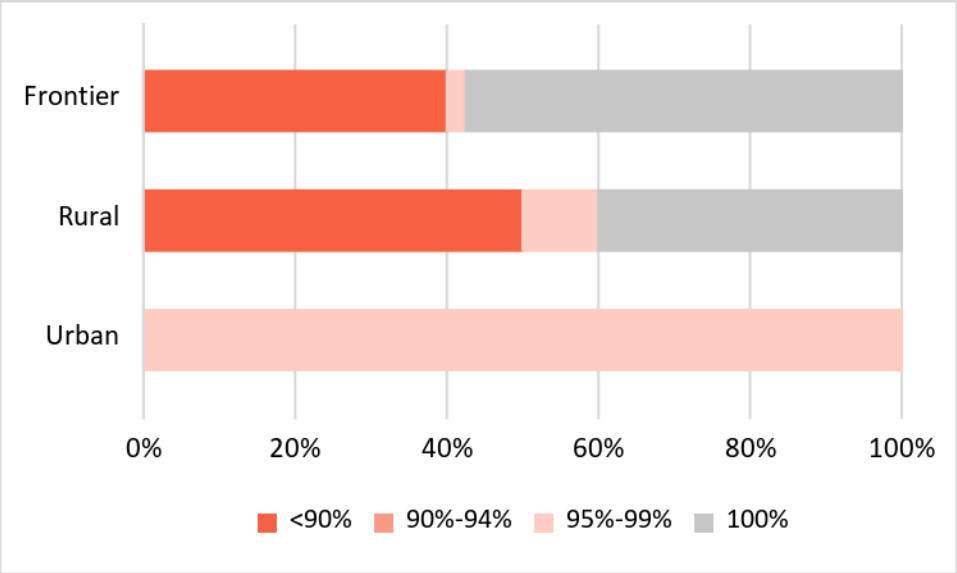
Minimum time and distance physical health primary care requirements include pediatric, adult, and family PCPs, as well as OB/GYN practitioners. The MCOs are required to ensure that all members have two PCPs from each specified network type available within the specified time and distance requirement. Since the MCOs are contracted to cover different Colorado counties, each combination of a network time and distance requirement and county is measured separately.

Not all members may reside within the MCOs' contractual minimum network requirements for two or more providers in a given network category. As such, Figure 4-5 summarizes the number of physical health primary care results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The top bar in Figure 4-5 reflects a total of 16 physical health primary care results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined Medicaid MCOs contracted to serve members residing in frontier counties. Of those 16 results, 37.5 percent (n=6) have 100 percent of MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 6.3 percent (n=1) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 56.3 percent (n=9) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).
- The middle bar in Figure 4-5 reflects a total of 32 physical health primary care results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined MCOs contracted to serve members residing in rural counties. Of those 32 MCO rural results, 40.6 percent (n=13) have 100 percent access level, 25.0 percent (n=8) of the results have 90 to 99 percent access level, and 34.4 percent (n=11) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-5 reflects a total of 32 physical health primary care results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined MCOs contracted to serve members residing in urban counties. Of those 32 MCO urban results, 18.8 percent (n=6) have 100 percent access level and 81.3 percent (n=26) of the results have 90 to 99 percent access level.

Figure 4-6 displays the percentage of physical health specialist requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of MCO members with access in the minimum network requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-6—Percentage of Aggregate MCO Physical Health Specialist Results Within the Time and Distance Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance physical health specialist requirements refer to practitioners such as cardiologists, endocrinologists, and gastroenterologists, and the MCOs are required to ensure that all members have one physical health specialist practitioner from each specified network type available within the minimum time and distance requirement.

Not all members may reside within the MCOs' contractual minimum network requirements for one provider in a given network category. As such, Figure 4-6 summarizes the number of physical health specialist results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

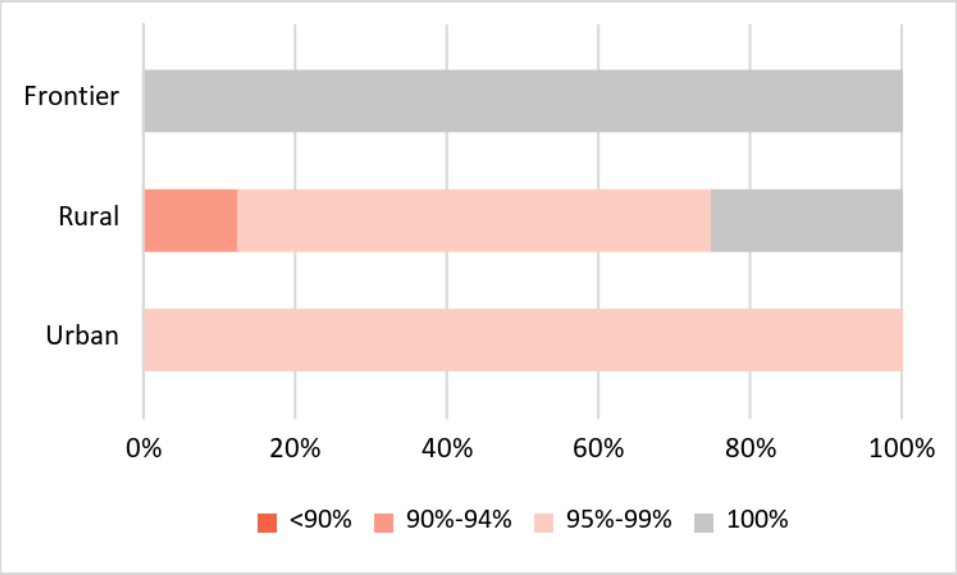
- The top bar in Figure 4-6 reflects a total of 40 physical health specialist results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined Medicaid MCOs contracted to serve members residing in frontier counties. Of those 40 results, 57.5 percent (n=23) have 100 percent of MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 2.5 percent (n=1) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 40.0 percent (n=16) of the results have less than 90 percent of members that reside

within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).

- The middle bar in Figure 4-6 reflects a total of 80 physical health specialist results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined MCOs contracted to serve members residing in rural counties. Of those 80 MCO rural results, 40.0 percent (n=32) have 100 percent access level, 10.0 percent (n=8) of the results have 90 to 99 percent access level, and 50.0 percent (n=40) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-6 reflects a total of 80 physical health specialist results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined MCOs contracted to serve members residing in urban counties. Of those 80 results, 100 percent (n=80) have 90 to 99 percent of members that reside within urban counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level).

Figure 4-7 displays the percentage of minimum time and distance physical health entity requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of MCO members with access in the network requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-7—Percentage of Aggregate MCO Physical Health Entity Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance physical health entity requirements include acute care hospitals and pharmacies. MCOs are required to ensure that all members have one physical health entity from each specified network type available within the specified time and distance network requirement.

Not all members may reside within the MCOs' contractual minimum network requirements for one entity in a given network category. As such, Figure 4-7 summarizes the number of physical health entity

results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The top bar in Figure 4-7 reflects a total of four physical health entity results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined MCOs contracted to serve members residing in frontier counties. Of those four results, 100 percent (n=4) have 100 percent of MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level).
- The middle bar in Figure 4-7 reflects a total of eight physical health entity results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined MCOs contracted to serve members residing in rural counties. Of those eight MCO rural results, 25.0 percent (n=2) have 100 percent access level and 75.0 percent (n=6) of the results have 90 to 99 percent of members that reside within rural counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level).
- The bottom bar in Figure 4-7 reflects a total of eight physical health entity results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined MCOs contracted to serve members residing in urban counties. Of those eight MCO urban results, 100 percent (n=8) of the results have 90 to 99 percent of members that reside within urban counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level).

Statewide Conclusions and Recommendations Related to Network Adequacy

The Department used the FY 2020–2021 NAV to expand prior years' NAV activities, requesting that HSAG begin quarterly validation of the health plans' self-reported compliance with minimum network requirements, and move the display of NAV results into interactive, web-based dashboards to facilitate the Department's comparison of quarterly NAV results across and within health plans, network requirements, and counties. The health plans' consistent use of Department-approved quarterly network adequacy reporting materials within a single fiscal year allowed the Department to begin evaluating the health plans' network data for consistent, complete reporting over time. The health plans' FY 2020–2021 Quarter 2 network adequacy reports reflected the first quarterly NAV cycle in which none of the health plans were required to resubmit their member or network data files, indicating an improvement in the health plans' ability to submit quarterly network adequacy reports and accompanying data files in alignment with the Department-approved reporting materials.

When reviewing the health plans' geoaccess compliance results and HSAG's corresponding NAV results, however, it is important to note that the health plans' contractual network requirements require the health plan to ensure that 100 percent of its applicable members have network access within the minimum time or distance requirements (i.e., 100 percent access level). If members reside in counties

outside their health plan's contracted geographic area, the Department does not necessarily require the health plan to meet the minimum time and distance network requirements for those members.

As a result, a health plan's failure to meet the minimum time or distance requirements for a network requirement may reflect different factors, including a lack of contracted healthcare practitioners; a nuance of the health plan's mapping between its network data and the Department's reporting templates; or a limited number of members whose travel time or distance to a practitioner, practice site, or entity is greater than the defined time and distance requirement. If a health plan had fewer than 100 percent of its members within the minimum network requirements, the health plan may have also made accommodations for members with special circumstances.

Table 4-6 displays the rate of compliance matches (i.e., HSAG agreed with the health plans' quarterly geoaccess compliance results), by health plan type and urbanicity. For example, HSAG agreed with 96.2 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties.

Table 4-6—Aggregate Percentage of Geoaccess Compliance Matches for FY 2020–2021 Quarter 2 by Health Plan Type and Urbanicity

Health Plan Type	Percentage of Matching Geoaccess Compliance Results in Frontier Counties	Percentage of Matching Geoaccess Compliance Results in Rural Counties	Percentage of Matching Geoaccess Compliance Results in Urban Counties
RAEs	96.2%	93.8%	79.8%
Medicaid MCOs	71.7%	80.8%	5.0%

To continue enhancement of its network adequacy oversight, the Department directed HSAG to modify the FY 2020–2021 quarterly network adequacy reporting materials to align with network needs that support ongoing service enhancements and network adequacy oversight, with the following examples:

- **Incorporation of SUD Treatment Network Data and Requirements**: HSAG and the Department updated quarterly network adequacy reporting documentation to reflect network requirements for DHMP's and the RAEs' coverage of SUD treatment services by American Society of Addiction Medicine (ASAM) levels of care, beginning with the health plans' FY 2020–2021 Quarter 3 network adequacy reports.
- **Network Crosswalk Updates to Consider *interChange* Definitions**: HSAG and the Department updated the Network Crosswalk document to incorporate information on *interChange* practitioner, practice site, and entity type and specialty definitions for network categories that align with the health plans' quarterly network requirements. Due to the nature of the *interChange* data, direct alignment does not exist between *interChange* practitioner definitions and the health plans' quarterly network adequacy reporting materials for all network categories. However, harmonizing the *interChange* and health plan network category descriptions where possible will facilitate network

data QI using comparisons between the health plans' network data and the *interChange* network data.

Due to the nature of the study methodology and data sources, key analytic considerations applicable to the FY 2020–2021 NAV results briefly include the following:

- Network categories in the FY 2020–2021 NAV results were limited to those reflected in the health plans' minimum network requirements, and HSAG validated only the health plans' self-reported time and distance geoaccess compliance results. Time or distance results represent a high-level measurement of the geographic distribution of network locations relative to members' place of residence, as reported by the health plan. Such raw, comparative statistics do not account for the individual status of a practitioner's panel (i.e., accepting or not accepting new patients) at a specific location or how active the network location is in the Health First Colorado program.
- Network data submitted to HSAG by the health plans may not reflect the current status of the health plans' networks or changes implemented since the January 2021 data submission deadline, and data may have included practitioners, practice sites, and entities that support additional healthcare services covered by Colorado's Health First Colorado program.
- NAV findings are dependent on the quality of member and network data supplied by the health plans, including the health plans' application of the Department-approved Network Crosswalk to attribute records to network categories. It was beyond the FY 2020–2021 NAV scope to evaluate the accuracy of the health plans' network data against an external network requirement (e.g., using telephone survey calls to verify the accuracy of network locations, contact information, or services offered).

Promising Practices and Opportunities for Improvement

Based on the FY 2020–2021 NAV process and analytic results, HSAG offers the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the health plans' compliance with network adequacy contract requirements and the provision of high-quality network data:

- **Enhance Network Data Quality**: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. Each health plan will be expected to use the detailed data quality results to improve the quality of their quarterly member and network data submissions to the Department.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the health plans' networks through the development and implementation of standardized quarterly network adequacy reporting materials. The Department has directed its EQRO to conduct the following activities during FY 2021–2022:
  - An evaluation of the existing process(es) by which the health plans are directed to request and receive exceptions to network requirements. If supported by the evaluation findings, the

Department may consider standardizing the health plan exception request documentation and processes to ensure uniform review and documentation of the health plans' network exceptions.

  - An evaluation of the appropriateness of the minimum time and distance network requirements in the health plans' contracts with the Department. The evaluation may also consider the extent to which the health plans offer alternate service delivery mechanisms to ensure members' access to care when minimum time or distance requirements may not be appropriate based on the geography and/or network category. For example, the Department may consider the extent to which a health plan offers and ensures that members are able to use telehealth modalities to obtain behavioral health services when practitioners are not available in rural or frontier counties.

- **Expand Network Adequacy Evaluation**: To further assess network availability, the Department should review ways to evaluate the health plans' compliance with contract network requirements for access to care, including the following:
  - Future access to care evaluations may incorporate the health plans' encounter data to assess members' utilization of services and potential gaps in access to care resulting from limited network availability.
  - The Department may also consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data available to the health plans' members and align with the network data supplied to the Department for the quarterly network adequacy compliance reporting.
  - In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department may choose to review member satisfaction survey results and grievance and appeals data to identify results and complaints related to members' access to care. Survey results and grievance and appeals data may 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 limited network availability.

Encounter Data Validation—RAE 411 Audit Over-Read

Statewide Results

Table 4-7 presents the RAEs' self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-7—RAEs' Aggregated, Self-Reported EDV Results by Data Element and BH Service Category

Data Element	Inpatient Services (614 Cases)	Ambulatory Inpatient Services (345 Cases)	Psychotherapy Services (959 Cases)	Residential Services (959 Cases)
Procedure Code	NA	95.1%	69.7%	91.1%
Principal Surgical Procedure Code	97.1%	NA	NA	NA
Diagnosis Code	89.4%	88.4%	79.5%	94.3%
Place of Service	NA	94.2%	78.4%	93.5%
Service Category Modifier	NA	94.8%	69.6%	91.2%
Units	NA	95.9%	87.0%	97.0%
Revenue Code	94.0%	NA	NA	NA
Discharge Status	97.4%	NA	NA	NA
Service Start Date	96.1%	95.9%	88.0%	97.2%
Service End Date	96.6%	95.9%	88.0%	97.1%
Population	NA	95.9%	87.8%	97.3%
Duration	NA	95.9%	83.8%	97.1%
Staff Requirement	NA	95.7%	86.3%	94.0%

NA indicates that a data element was not evaluated for the specified service category.

Table 4-8 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with the RAEs' aggregated EDV results for each of the validated data elements.

Table 4-8—Statewide Aggregated Encounter Over-Read Agreement Results for RAEs by BH Service Category

Data Element	Inpatient Services (44 Over-Read Cases)	Ambulatory Inpatient Services (26 Over-Read Cases)	Psychotherapy Services (70 Over-Read Cases)	Residential Services (70 Over-Read Cases)
Procedure Code	NA	96.2%	91.4%	94.3%
Principal Surgical Procedure Code	100%	NA	NA	NA
Diagnosis Code	97.7%	96.2%	97.1%	95.7%
Place of Service	NA	23.1%	100%	97.1%
Service Category Modifier	NA	38.5%	94.3%	97.1%
Units	NA	96.2%	100%	98.6%
Revenue Code	95.5%	NA	NA	NA
Discharge Status	70.5%	NA	NA	NA
Service Start Date	95.5%	96.2%	100%	98.6%
Service End Date	95.5%	96.2%	100%	97.1%
Population	NA	96.2%	100%	98.6%
Duration	NA	96.2%	98.6%	98.6%
Staff Requirement	NA	96.2%	95.7%	95.7%

NA indicates that a data element was not evaluated for the specified service category.

Statewide Conclusions and Recommendations Related to RAE 411 Over-Read

FY 2020–2021 is the second year in which the RAEs have used MRR to validate BH encounter data under the Department's guidance, and the EDV results allow the RAEs and the Department to monitor QI within the RAEs' BH encounter data. HSAG's over-read results suggest a high level of confidence that the RAEs' independent validation findings accurately reflect their encounter data quality, with the exception of ambulatory inpatient services cases, specifically the *Place of Service* and *Service Category Modifier* encounter data elements.

Based on the EDV and over-read results, HSAG recommends that the Department collaborate with the RAEs to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of the RAEs' provider training and/or corrective action documentation, reviewing the RAEs' policies and procedures for monitoring providers' BH encounter data submissions, and verifying that the RAEs are routinely monitoring encounter data quality beyond the annual RAE 411 EDV. 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 QI.

Encounter Data Validation—MCO 412 Audit Over-Read

Statewide Results

Table 4-9 presents the MCOs' self-reported encounter data service coding accuracy results, aggregated for both MCOs by service category and validated data element.

Table 4-9—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	90.8%	91.7%	89.3%	91.3%	90.8%
Through Date	90.3%	NA	NA	NA	90.3%
Diagnosis Code	83.5%	89.8%	83.0%	62.1%	79.6%
Surgical Procedure Code	76.2%	NA	NA	NA	76.2%
Discharge Status	85.4%	NA	NA	NA	85.4%
Procedure Code	NA	89.8%	82.0%	85.9%	85.9%
Procedure Code Modifier	NA	91.7%	85.0%	82.0%	86.2%
Units	NA	90.3%	86.9%	90.3%	89.2%

** Each service category reflects a different number of cases based on the modified denominators reported in each MCO's 412 Service Coding Accuracy Report Summary.*

NA indicates that a data element was not evaluated for the specified service category.

Table 4-10 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 4-10—Statewide Aggregated Encounter Over-Read Agreement Results for MCOs by Service Category

Service Category	Case-Level Accuracy—Total Number of Cases	Case-Level Accuracy—Percent With Complete Agreement	Element-Level Accuracy—Total Number of Elements	Element-Level Accuracy—Percent With Complete Agreement
Inpatient	40	92.5%	240	97.5%
Outpatient	40	85.0%	200	95.0%
Professional	40	100%	200	100%
FQHC	40	72.5%	200	93.0%
Total	**160**	**87.5%**	**840**	**96.4%**

Overall, results from HSAG's FY 2020–2021 MCO 412 EDV over-read showed that HSAG's reviewers agreed with the MCOs' reviewers for 87.5 percent of the over-read cases and 96.4 percent of individual encounter data elements.

Statewide Conclusions and Recommendations Related to MCO 412 Over-Read

Results from HSAG's 412 EDV over-read suggest a moderate level of confidence for RMHP and a high level of confidence for DHMP that the respective MCOs' independent validation findings accurately reflect the encounter data quality summarized in their service coding accuracy results.

The MCOs' 412 EDV results and HSAG's subsequent over-read demonstrate targeted opportunities for improvement in the MCOs' oversight of data submissions from their providers. HSAG recommends the Department collaborate with each MCO to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of the MCO's provider training and/or corrective action documentation, reviewing the MCO's policies and procedures for monitoring providers' physical health encounter data submissions, and verifying that the MCO is routinely monitoring encounter data quality beyond the annual 412 EDV.

PCMH CAHPS Surveys—RAEs

Statewide Results

Adult

Table 4-11 shows the adult PCMH CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2020–2021.

Table 4-11—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	72.4%	75.3% ↑	71.3%	66.4%	59.7% ↓	69.0%	68.7%	68.0%
Rating of Specialist Seen Most Often	65.8%	73.0%	69.3%	68.9%	61.3%	64.3%	67.9%	65.9%
Rating of All Health Care	68.1%	71.1% ↑	66.3%	61.7%	55.8% ↓	67.7%	65.8%	64.0%
Rating of Health Plan	65.4%	72.5%	66.4%	65.5%	65.9%	66.5%	63.8%	65.8%
Getting Timely Appointments, Care, and Information	53.1%	57.5% ↑	46.0% ↓	59.9% ↑	50.1%	44.6% ↓	53.2%	49.0%
How Well Providers Communicate with Patients	78.6%	78.4%	75.9%	80.0%	66.5% ↓	77.4%	80.5% ↑	76.2%
Providers' Use of Information to Coordinate Patient Care	66.3%	65.1%	64.7%	62.5%	52.9% ↓	64.3%	69.0% ↑	63.3%
Talking with You About Taking Care of Your Own Health	51.4%	47.5%	49.8%	50.6%	48.4%	50.1%	51.6%	50.3%
Comprehensiveness	55.8% ↑	50.7%	53.5%	46.9% ↓	38.7% ↓	59.5% ↑	55.2% ↑	53.5%
Helpful, Courteous, and Respectful Office Staff	74.4% ↑	75.4% ↑	68.8%	73.4%	66.5% ↓	67.9%	70.0%	69.2%
Customer Service	67.8%	65.0%	61.5%	64.1%	57.4%	65.1%	60.2%	63.2%

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	37.5% ↑	33.0%+	24.2%	35.9%+	25.5%+	19.4% ↓	20.1%+	25.9%
Reminders About Care from Provider Office	74.3%	69.0%	74.2%	72.0%	69.4%	73.3%	77.3%	73.3%
Saw Provider Within 15 Minutes of Appointment	44.4%	55.1% ↑	41.9%	43.3%	37.4% ↓	41.9%	50.7% ↑	43.1%
Receive Health Care and Mental Health Care at Same Place	60.1%	65.5%	63.4%	60.1%	57.1%	60.8%	49.7% ↓	62.3%

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.

**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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the Colorado RAE aggregate.*

Child

Table 4-12 shows the child PCMH CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2020–2021.

Table 4-12—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	76.6%	68.0%+ ↓	79.7%	73.5%	87.8% ↑	81.4%	81.5%	79.7%
Rating of Specialist Seen Most Often	73.7%+	82.1%+	71.4%	60.3%+	72.4%+	76.8%+	72.2%	70.3%
Rating of All Health Care	73.7%	72.3%+	80.3%	73.5%	88.9% ↑	78.8%	80.8%	79.2%
Getting Timely Appointments, Care, and Information	58.2%+ ↓	66.7%+	67.0%	60.1% ↓	77.3% ↑	79.6% ↑	77.0% ↑	67.7%

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
How Well Providers Communicate with Child	68.0%+ ↓	75.4%+	80.6%	75.5%	90.9% ↑	85.9% ↑	81.1%	80.0%
How Well Providers Communicate with Parents or Caretakers	77.2% ↓	75.0%+ ↓	84.4%	79.8%	88.5% ↑	86.8% ↑	88.3% ↑	83.5%
Providers' Use of Information to Coordinate Patient Care	72.7%	65.3%+	75.9%	74.0%	79.4%	81.5%	74.1%	74.8%
Comprehensiveness—Child Development	63.7%	64.8%+	70.1%	57.5% ↓	74.8% ↑	73.8% ↑	70.7%	68.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	59.0%	56.2%+	64.2% ↑	48.3% ↓	65.0% ↑	66.9% ↑	61.4%	61.8%
Helpful, Courteous, and Respectful Office Staff	65.6% ↓	71.7%+	67.0% ↓	59.5% ↓	83.5% ↑	85.4% ↑	74.3%	69.6%
Received Information on Evening, Weekend, or Holiday Care	83.0%	76.0%+	81.4%	73.8% ↓	88.4% ↑	86.0%	83.7%	81.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	52.0%+	32.9%+	44.8%+	31.0%+	58.7%+	40.9%+	45.5%+	43.1%
Reminders About Child's Care from Provider Office	59.7% ↓	59.6%+	75.5% ↑	58.4% ↓	80.7% ↑	69.7%	69.0%	69.7%
Saw Provider Within 15 Minutes of Appointment	40.4% ↓	49.2%+	44.1% ↓	37.5% ↓	59.8% ↑	67.6% ↑	50.9%	46.5%

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.

**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 2020–2021 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2020–2021 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 across the quality of care, access to care, and timeliness of care domains. HSAG recommends that the Department consider prioritizing one to three of these measures for developing statewide improvement initiatives with performance goals designed to improve member perceptions within the chosen measures.

Of note, the State's three most rural RAE regions (RAE regions 1, 2, and 4) had fewer 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). However, RAE Region 3, which is considered within the Denver metropolitan area, had only one measure score that was statistically significantly lower than the Colorado RAE aggregate. RAE Region 5 experienced the greatest number of measure scores that were statistically significantly lower than the Colorado RAE aggregate (seven measure scores). The Department may want to focus efforts on evaluating key drivers for these measure rates in Colorado's most urban regions.

The Department may also want to consider working with the RAEs that received no scores that were statistically significantly lower than the Colorado RAE aggregate in FY 2020–2021 on specific measures to develop and share best practices with other RAEs that show opportunities for improvement for the same measures.

RAE Child Survey

Four RAE regions had scores that were statistically significantly lower than the Colorado RAE aggregate for a total of 10 measures across the timeliness, access, and quality of care domains. Three RAE regions had statistically significantly lower scores than the Colorado RAE aggregate for two of these measures (*Helpful, Courteous, and Respectful Office Staff* and *Saw Provider Within 15 Minutes of Appointment*) and two RAE regions had statistically significantly lower scores than the Colorado RAE aggregate for three of these measures (*Getting Timely Appointments, Care, and Information*; *How Well Providers Communicate with Parents or Caretakers*; and *Reminders About Child's Care from Provider Office*). HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions of access to and timeliness of care 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 (seven measure scores). The Department may want to consider working with the RAEs that received no scores that were statistically significantly lower than the Colorado RAE aggregate in FY 2020–2021 on specific measures to develop and share best practices with other RAEs that show opportunities for improvement for the same measures.

CAHPS Survey—MCOs

Statewide Results

Table 4-13 shows the adult Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2020–2021.[4-1]

Table 4-13—FY 2020–2021 Adult Medicaid CAHPS Results for MCOs

Measure	DHMP	RMHP Prime
Getting Needed Care	84.1% ▲	83.5%
Getting Care Quickly	79.9%	80.2%+
How Well Doctors Communicate	94.2%	92.1%
Customer Service	91.5%	89.7%+
Rating of Personal Doctor	77.7% ↑	67.9%
Rating of Specialist Seen Most Often	63.2%	69.7%+
Rating of All Health Care	58.1%	53.9%
Rating of Health Plan	58.0%	55.1% ↓ ▼

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.

↑ *Indicates the FY 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*
↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Table 4-14 shows the child Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2020–2021.[4-2]

Table 4-14—FY 2020–2021 Child Medicaid CAHPS Results for MCOs

Measure	DHMP	RMHP Prime
Getting Needed Care	84.8%+	86.3%
Getting Care Quickly	89.0%+	91.1%
How Well Doctors Communicate	96.3%+	97.4% ↑
Customer Service	91.3%+	89.3%+

[4-1] 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.

[4-2] 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.

Measure	DHMP	RMHP Prime
Rating of Personal Doctor	80.6%	75.0%
Rating of Specialist Seen Most Often	80.8%+	73.0%+
Rating of All Health Care	76.5%+	74.7%
Rating of Health Plan	68.4%	69.9%

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 2020–2021 score is statistically significantly higher than the 2020 NCQA national average.*

↓ *Indicates the FY 2020–2021 score is statistically significantly lower than the 2020 NCQA national average.*

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Statewide Conclusions and Recommendations Related to MCO CAHPS

For the adult Medicaid population, DHMP did not score statistically significantly lower in FY 2020–2021 than in FY 2019–2020 or statistically significantly lower than the 2020 NCQA national average on any measure. RMHP Prime scored statistically significantly lower in FY 2020–2021 than in FY 2019–2020 and statistically significantly lower than the 2020 NCQA national average on one measure, *Rating of Health Plan*. For the child Medicaid population, DHMP and RMHP Prime did not score statistically significantly lower than the 2020 NCQA national average on any measure. Since the *Rating of Health Plan* measure is most closely associated with the quality domain of care, HSAG recommends that the Department work with RMHP Prime to determine what may drive low scores by adult members for this measure. For example, a root cause analysis can be performed to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. Also, an assessment of customer service processes may provide additional information, as customer service is often the first contact point for members. Similarly, an assessment of utilization review turnaround times and of care coordination processes, if a large portion of members receive care coordination, may provide valuable information. The Department may want to collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of quality of care. In addition, the MCOs may want to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters.

5. Assessment of Health Plans' Follow-Up on FY 2019–2020 Recommendations

Region 1—Rocky Mountain Health Plans

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two RMHP PIPs: The *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP and the *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for RMHP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-1 summarizes RMHP's PIP close-out report.

Table 5-1—RMHP FY 2019–2020 PIP Close-Out Summary

***Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP**	
Interventions	Registry-based automated text outreach system for well-child visits.
Successes	• Established a registry-based automated text outreach system. • Gained information on which members could not be reached, which will be used to explore alternative outreach methods.
Lessons Learned	• Increased understanding and competence in using text platforms for large-scale outreach efforts. • Member response to text outreach was lower than expected, suggesting that additional refinement of outreach methods is needed to best reach the adolescent member population.
***Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP**	
Interventions	Relatient Health text message outreach campaign targeted toward members due for well-care visit, which would include depression screening.
Successes	• Established data-driven tracking mechanism for outreach and scheduling well visits. • Improvement in depression screening rates during the project.
Lessons Learned	Consistent provider partner training on intervention and coding is essential to successful improvement.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, RMHP reported that it implemented the following interventions:

- In late spring 2021, RMHP compiled a list of all performance measures, including BHIP measures, across all programs in an effort to categorize measures into eight subgroups. For each subgroup, a subcommittee of the QI committee was formed, one of which was assigned BH/SUD. This subcommittee was responsible for understanding the specifications within the BHIP measures; monitoring performance; and working to develop plan-level, provider-level, and member-level interventions to improve performance. Within this restructure, effort was put toward aligning work within programs with similar metrics and outcome expectations. In addition, RMHP has increased the focus on BH quality assurance and quality auditing. This audit process helps to inform improvement opportunities related to services provided to improve performance measure rates.
- RMHP re-initiated the development of an internal BHIP dashboard using the Colorado Department of Health Care Policy & Financing (HCPF) Structured Query Language (SQL) coding for calculation of BHIP metrics. This work began toward the beginning of the fiscal year and is slated to be completed in fall 2021. This dashboard will be used to provide more timely tracking and

monitoring of performance within the BHIP program and to inform more timely intervention development.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement in two standards that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, RMHP was required to complete three corrective actions:

- Correct UM policies to address the 10-calendar-day time frame for standard authorization decisions.
- Correct UM policies to address 14-calendar-day extensions for both standard and expedited authorization decisions.
- Ensure notices of adverse benefit determination (NABDs) are written in a manner that is easy for a member to understand (i.e., at or below the sixth grade reading level).

Related to Standard VI—Grievance and Appeal Systems, RMHP was required to complete five required actions:

- Develop a mechanism to ensure grievances regarding treatment are reviewed by someone with clinical expertise.
- Ensure each grievance is thoroughly addressed.
- Communicate the appeal resolution and reason for the decision in member-friendly language.
- Update policies to accurately reflect continuation of benefits information (two required actions).

RMHP submitted its initial CAP proposal in June 2020. Following Department approval, RMHP successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a Quality Improvement Plan (QUIP) follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and RMHP developed targeted interventions to address high-priority failure modes. Over the course of three months, RMHP monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, RMHP noted improvement in 10 of the 11 prevention/early intervention (PEI) encounter data elements, five of the 11 club house/drop-in encounter data elements, and all 11 residential encounter data elements. RMHP's QUIP addressed lack of minimum supporting documentation and missing patient identifiers in medical records and included corrective action to implement additional education and training for providers. HSAG recommended that RMHP continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, RMHP reported engaging in the following QI initiatives:

- Implemented a process by customer service to notify provider relations when they are informed by members that a healthcare provider is not accepting new patients, or is requiring applications for acceptance. Provider relations will follow up with the provider to investigate and address the member's concern.
- During member welcome calls, customer service educates members on the importance of having a primary care relationship with a PCP. Customer service asks the member if they have a PCP and if so, if they have an appointment coming up. If they do not have a PCP, customer service offers to help the member find one and connect them with the office to schedule an appointment.
- Discussed a CAHPS educational video series during value-based contracting office hours with practices. In addition, the videos are available on the RMHP website. The goal was to increase provider awareness of the CAHPS survey and encourage primary care providers to deliver high-quality patient-centered care.
- Made a Podcast series available on Podbean and the RMHP website. It includes interviews with healthcare professionals with tips about improving communication and building patient relationships.
- Included member experience topics in newsletter articles, learning collaborative events, and the webinar series. Topics included leadership training, behavioral health skills training, care management training, medical assistant skills and training, and telehealth visits.

Region 2—Northeast Health Partners

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two NHP PIPs: The *Increasing Well Checks for Members 21–64 Years of Age* PIP and the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for NHP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-2 summarizes NHP's PIP close-out report.

Table 5-2—NHP FY 2019–2020 PIP Close-Out Summary

***Increasing Well Checks for Members 21–64 Years of Age* PIP**	
Interventions	Text-based outreach campaign targeting 21–64-year-old male members who were due for a well visit. Text messages included direct link to phone-based or text-based appointment scheduling with provider partner.
Successes	Well visit rates increased during the project.
Lessons Learned	• Real-time data needs for the PIP should be communicated clearly and in detail with the partner provider; roles and responsibilities should be established prior to intervention initiation.

Increasing Well Checks for Members 21–64 Years of Age PIP	
	• Provider and member buy-in for interventions would be enhanced if PIP topics and target populations can be aligned with the provider partner's population health initiatives.
***Increasing Mental Healthcare Services After a Positive Depression Screening* PIP**	
Interventions	Communication with providers regarding knowledge and practices related to appropriate depression screening coding and reporting; development of related provider training materials.
Successes	Provider training materials on documenting and billing for a depression screen were developed and are available for future training and improvement efforts.
Lessons Learned	• Without accurate and timely data (removal of SUD and limited claims submission), it is impossible to understand where performance deficits exist, and which interventions should be implemented. • Billing procedures and requirements highly impact provider interest in submitting data for coding completed depression screens.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, NHP reported that it implemented the following interventions:

- Increasing access to SUD services is a focus for Region 2, and is outlined as a key component of NHP's Behavioral Health Expansion Plan with an emphasis on pediatric SUD services. Further, SUD remains one of the highest potentially avoidable complications (PACs) costs for the region, and NHP strategically aligned its FY 2021–2022 PAC plan to include SUD as a focus. This alignment will help support network expansion, identify service gaps, help lower SUD costs, and should also impact BHIP performance for the two SUD-specific measures.
- Implemented a PIP focused around depression screening and follow-up rates. This initiative enabled NHP to outline screening and follow-up processes in addition to implementing a performance improvement initiative at a clinic.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, NHP was required to complete one corrective action:

- Ensure the NABD letters are written in a language that is easy for the member to understand.

For Standard II—Access and Availability, NHP was required to complete one corrective action:

- Develop a robust mechanism to monitor timely access to services.

For Standard VI—Grievance and Appeal Systems, NHP was required to complete eight corrective actions:

- Develop a mechanism to ensure the grievance resolution letter is easy for the member to understand.
- Ensure that all standard appeal decisions are made within 10 working days from receipt, unless the time frame is extended, and ensure the appeal resolution letter is easy for the member to understand.
- Develop a mechanism to ensure that written notice to the member of an expedited appeal decision is sent within 72 hours of receipt of the expedited appeal request.
- Five required actions related to State fair hearing (SFH) requirements and time frames for filing in policies and procedures, appeal resolution letters, and the information distributed to providers.

NHP submitted its initial CAP in June 2020. Following Department approval, NHP successfully completed implementation of all planned interventions in January 2021.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and NHP developed targeted interventions to address high-priority failure modes. Over the course of three months, NHP monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, NHP reached over 90 percent compliance for seven out of 11 encounter data elements in the PEI claim type, 10 out of 11 encounter data elements in the club house/drop-in claim type, and one out of two encounter data elements in the residential claim type. Most notably, all club house/drop-in encounter data elements improved to 100 percent in month one, and again by month three with the exception of the *Procedure Code* encounter data type. Within the residential claim type, the *Procedure Code* encounter data element improved from 15 percent to 100 percent, and several PEI data elements improved to 100 percent in each of the first through third intervention months. The club house/drop-in *Procedure Code* encounter data element rose to 100 percent compliance in months one and two but declined again to 10 percent in month three due to a lack of substantiating documentation. NHP's QUIP key interventions included corrective action training on the technical requirements and best practice documentation for each low-scoring encounter data element. NHP reported continued efforts toward improving the documentation necessary to increase encounter data accuracy. HSAG recommended that NHP continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, NHP reported engaging in the following QI initiatives:

- Utilized member experience data collected through the CAHPS survey to develop resources and interventions that are specific to the documented experience of members. These opportunities were identified by NHP leadership with Beacon providing administrative oversight to any subsequent materials, trainings, or outreach. NHP intends to continue to analyze the data, compare to the previous year's performance, and address areas of underperformance.

Region 3—Colorado Access

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two COA Region 3 PIPs: The *Well-Child Visits for Members 10–14 Years of Age* PIP and the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for COA Region 3 to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-3 summarizes COA Region 3's PIP close-out report.

Table 5-3—COA Region 3 FY 2019–2020 PIP Close-Out Summary

Well-Child Visits for Members 10–14 Years of Age PIP	
Interventions	In-person provider training on best practices for billing for well visits provided collaboratively by the EMR and data analytics teams.
Successes	Established data sharing and a monthly reporting process with provider partner.
Lessons Learned	The importance of clearly communicating PIP requirements/expectations—interventions and data collection—to the provider partner and obtaining buy-in/commitment from the provider partner up front.

Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age PIP	
Interventions	Planned development and dissemination of provider education on qualifying follow-up services and appropriate billing practices focused on integrated primary/behavioral health sites.
Successes	• Established a strong relationship and increased communication with provider partner. • Established a collaborative relationship with another RAE (Region 6) to support larger regional improvement efforts. • Positive depression screening follow-up visit rates improved during the project.
Lessons Learned	• Identification of a primary process flaw related to low outcome measure rates: inappropriate coding practices led to underreporting of positive depression screens. • Partnering with other health plans/RAEs can be an effective strategy to engage providers and drive improvement. • The importance of involving administrators and clinicians in early PIP planning to help avoid billing and coding issues that may impact project performance, as was encountered in this project.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, COA Region 3 reported that it implemented the following interventions:

- As far as BH engagement goes, in September 2020, COA Region 3 expanded the established Pay for Performance (P4P) Workgroup structure to begin holding a series of monthly workgroups with providers designed to address and improve on certain prioritized key performance indicators (KPIs). The KPI Provider Workgroups were developed in an effort to drive performance for the Well Visit, Dental, and Behavioral Health Engagement KPIs. Although these workgroups focused on KPI improvement, the efforts around Behavioral Health Engagement will result in benefits that intersect with the Behavioral Health Incentive measures as the areas of care and services overlap in many metrics. These workgroups were designed as a space for collaborating and sharing best practices to drive performance and inform opportunities for the RAE to apply across the network. The benefits of these workgroups are multifold. COA Region 3 has identified barriers and areas of opportunity, gained significant knowledge on strengths and best practices, and strengthened provider alliances through these workgroups. Although final performance rates are pending for FY 2021, the momentum of the workgroups will be continued into FY 2022 to focus on metric improvement and provider collaboration.
- For the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* measure, COA Region 3 will continue to use its sophisticated internal admission, discharge, transfer (ADT) system to alert community mental health centers (CMHCs) of new

admissions to inpatient care. This has allowed COA Region 3 to get involved in a timelier fashion to aid in disposition planning. Institutes for Mental Disease (IMDs) have been on a value-based contract for seven-day follow up and, in most cases, have increased their rates. COA Region 3's dashboard helps alert it to those hospitals having difficulty. COA Region 3 then sets up meetings for the hospital and typical outpatient partners to aid in communication and process building.

- For the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure, COA Region 3 has been meeting with the Region 3 Department of Human Services (DHS) teams to discuss this measure and try to promote practices to connect foster care children to primary care quickly. DHS county partners all have different procedures and do not direct members to specific partnering PCPs. This has been a struggle for COA Region 3, as COA Region 3's target for communication is the PCP. COA Region 3 continues to work with the count department of human service to problem solve.
- For the *Follow-Up After a Positive Depression Screen* measure, COA Region 3 has educated providers on screening and follow-up after a positive depression screen through multiple different venues. Provider workstreams have been examined with an emphasis on connecting primary care medical providers (PCMPs) to behavioral health organizations to ensure referral streams so that members can get follow-up care if a BH specialists is not integrated within the PCMP practice.
- For the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* measure, COA Region 3's continued target has largely been with medication-assisted treatment (MAT)/opioid use disorders, but COA Region 3 has since developed new programing—incentivizing engagement after a 3.2 withdrawal management (WM) visit. This helps capture the other SUDs. Education sessions for all regional emergency departments (EDs) in terms of SUD services and referrals also help with engagement.
- For the *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* measure, COA Region 3 worked with EDs and 3.2 WM facilities (as many times members go from ED to 3.2 WM) to educate and incentivize engagement. For the 3.2 WM value-based contracts, COA Region 3 has defined engagement as three treatment appointments within 30 days of discharge from WM.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement in two standards that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, COA Region 3 was required to:

- Ensure that RAE members 1) receive written notification of any decision to deny a service, including denial or partial denial of a claim; 2) that the NABD is written in a language that is easy for the member to understand; and 3) that the NABD includes all required content.

- Update policies to 1) include accurate time frames, including exceptions, for NABD mailings and 2) ensure members receive written notification of any denial of a service, including partial denials.
- Revise UM and claims payment procedures to clarify post-stabilization procedures.
- Implement a mechanism to ensure grievances that involve clinical issues are sent to individuals with clinical expertise for resolution.

For Standard VI—Grievance and Appeal Systems, COA Region 3 was required to:

- Ensure that grievance acknowledgement letters are sent within time frames; grievance resolution letters are sent within time frames and easy for the member to read; and, if grievance extension letters are sent, they include the member's right to file a grievance if the member disagrees with the extension.
- Ensure appeal resolution letters are easy for the member to read.
- Revise appeal resolution letters to ensure that only the information pertaining to the member's right to an SFH is included.
- Update policies to accurately depict a member's right to request continuation of benefits and associated timelines during appeals and SFHs.

COA Region 3 submitted its initial CAP in May 2020. Following Department approval, COA Region 3 successfully completed implementation of all planned interventions in November 2020.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and COA Region 3 developed targeted interventions to address high-priority failure modes. Over the course of three months, COA Region 3 monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, COA Region 3 reached over 90 percent compliance for three out of four PEI encounter data elements, one out of three club house/drop-in encounter data elements, and 10 out of 10 residential encounter data elements. Most notably, all 10 residential encounter data elements improved to 100 percent in the first intervention month and maintained 100 percent compliance throughout the intervention period. COA Region 3's QUIP included provider education and training, EMR adjustments

to correctly populate certain encounter data types, and implementation of internal provider systems to assure completion of required documentation. COA Region 3 noted future interventions involving training and education will include more specific detail to address lower accuracy rates in the PEI and club house/drop-in claim types. HSAG recommended COA Region 3 continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, COA Region 3 reported engaging in the following QI initiatives:

- Continued to run internal rating measures examining customer service ratings by an external organization that provides timely feedback to customer service managers who can address ratings of associates and remedy issues immediately.
- Promoted and educated customer service and care management teams regarding the purpose of the survey for the first time to increase response rates and for more actionable feedback.
- The quality department presented to the Member Advisory Committee to share results and obtain feedback regarding *Health First Colorado Customer Service* and *Rating of Specialist Seen Most Often*.
- Administered a third iteration of the Customer Satisfaction Survey for continued and more up-to-date identification of improvement area opportunities.
- Introduced new collaborative efforts within customer service, care management, and provider relations to develop processes to increase information sharing for targeted secret shopper calls to 1) better understand member experience and 2) initiate interventions to improve experience.
- Implemented a member satisfaction survey on incoming calls in June 2020, which was administered by COA Region 3 customer service representatives. The member satisfaction survey is intended to solicit feedback from Health First Colorado members to ensure providers' excellent customer service and improve provider network issues. The Member Advisory Council was utilized to solicit feedback and input on the survey questions and direction. The first iteration of the survey focused on access and quality of care to understand members' experience in their physician's office or telehealth setting, and the subsequent iteration of the survey focused on health equity. This survey provided a valuable opportunity to hear from members and understand their care experience. The responses from the survey will improve how COA Region 3 interacts with and advocates for members by understanding their experiences. Within this survey, members' needs are also addressed by responding to dissatisfactory experiences with referral resources or additional coordination as needed at the time of the survey, which helps satisfy members' needs immediately. The customer service representatives have provided 220 referrals in real time to immediately assist and connect members with resources or services. Since its launch, nearly 2,000 surveys have been completed.
- Provider relations representatives collaborated with PCMH CAHPS practices to help improve response rates for more meaningful and actionable feedback.

- Monitored providers on access to care standards quarterly by conducting a series of calls to practices that mirror common member behavior to test the consistency of the provider behavior and availability of services offered to members. This activity checks for timeliness of appointment availability to validate compliance with standards as well as quality of calls. Targeted secret shopper calls in FY 2020–2021 Q3 were delivered to PCMH practices identified within the PCMH CAHPS participants to anticipate and correct any deficiencies prior to receiving PCMH CAHPS final reports in August/September. This was to compare results once the final report was delivered and to also receive more timely results on access to care and create interventions for improvement in a timely manner.

Region 4—Health Colorado, Inc.

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two HCI PIPs: The *Increasing Well Checks for Members 21–64 Years of Age* PIP and the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for HCI to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-4 summarizes HCI's PIP close-out report.

Table 5-4—HCI FY 2019–2020 PIP Close-Out Summary

Increasing Well Checks for Members 21–64 Years of Age PIP	
Interventions	Telephone outreach by care coordinators to 21–64-year-old male members due for a well visit; outreach calls included reminder and assistance with appointment scheduling.
Successes	Well visit rates increased during the project.

Increasing Well Checks for Members 21–64 Years of Age PIP	
Lessons Learned	• Live, personal phone outreach by care coordinators was resource-intensive and limited the number of members who could be targeted for outreach each month. • Revisions for the intervention considered by the health plan include increasing the scope of outreach (more members per month) and focusing on members who had previously been seen by the partner provider (established patients).
***Increasing Mental Healthcare Services After a Positive Depression Screening* PIP**	
Interventions	Use of real-time EHR data dashboard to identify members with positive depression screens and member outreach by a behavioral health clinician to schedule follow-up appointment and offer resources (transportation); behavioral health clinician also conducted phone outreach for missed appointments.
Successes	Enhanced EHR dashboard to enable real-time tracking of positive depression screens and follow-up appointments.
Lessons Learned	Without accurate and timely data (removal of SUD and limited claims submission), it is impossible to understand where performance deficits exist, and which interventions should be implemented.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, HCI reported that it implemented the following interventions:

- Created a Performance Measures Action Plan (PMAP) that served as a mechanism to further the performance measures strategic planning efforts and to drive performance improvement in collaboration with key stakeholders. Created as a collaborative to promote learning and improvement, the PMAP Workgroup meets weekly (bimonthly at a minimum) and reports to the RAE Quality Committee monthly. Key stakeholders involved in the effort are partners/providers, quality management staff members, and members of the RAE Quality Committee.
- Reviewing performance in relation to benchmarks/goals/targets, the PMAP Workgroup will periodically rank order measures, determining which measures to focus performance improvement activity on within a rapid cycle framework. The workgroup will be comprised of key partners/providers identified as strong performers to identify and document best practices as well as partners/providers with opportunities for improvement, who are willing to implement best practices. The workgroup will report its activities in the monthly RAE Quality Committee meetings, including review of RAE and provider-level performance data and identifying potential countermeasures to increase overall performance.
- The initial workgroup will begin to focus on prioritized measures in early FY 2021–2022. Partner/provider representatives will be invited on an ad hoc basis to the workgroup meetings to review the performance data and make recommendations with feedback and support from the RAE Quality Committee. Once a meaningful, manageable, and measurable set of interventions are

identified and approved by the RAE Quality Committee, the workgroup will coordinate with partners/providers to implement the countermeasures and monitor performance over time, sharing their findings with the RAE Quality Committee monthly. The workgroup will follow a rapid cycle, iterative process of planning, taking action (countermeasures), studying and monitoring performance, and acting on what is learned.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, HCI was required to complete one corrective action:

- Ensure the NABD letters are written in a language that is easy for the member to understand.

For Standard II—Access and Availability, HCI was required to complete one corrective action:

- Develop a robust mechanism to monitor timely access to services.

For Standard VI—Grievance and Appeal Systems, HCI was required to complete six corrective actions:

- Develop a mechanism to ensure the description of the grievance resolution in the member letter thoroughly addresses the member's complaint.
- Five required actions related to SFH requirements and time frames for filing in policies and procedures, appeal resolution letters, and the information distributed to providers.

HCI submitted its initial CAP in June 2020. Following Department approval, HCI successfully completed implementation of all planned interventions in January 2021.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and HCI developed targeted interventions to address high-priority failure modes. Over the course of three months, HCI monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, HCI improved its one encounter data element, PEI procedure code, from a baseline of 87 percent accuracy to 100 percent accuracy. HCI's QUIP focused on provider training. HSAG recommended HCI continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, HCI reported engaging in the following QI initiatives:

- Addressed the CAHPS data and low-scoring elements notated in the survey at the HCI Quality Improvement Utilization Management (QIUM) committee. It was determined that low scoring elements for Valley-Wide Health Systems (Valley-Wide) would be examined for patient experience improvement. HCI and Valley-Wide met to address areas where their performance was below the mean for providers in their region. Valley-Wide determined that they would like to focus on areas in the survey that were related to access to care for children. Valley-Wide will focus on questions 13, 15 and 18. Beginning in May of 2020 and continuing every six months, Valley-Wide healthcare clinics are contacted via telephone to inquire about appointment availability. HCI will continue to work with Valley-Wide to address areas of low performance. HCI intends to analyze the data, address areas of underperformance, as well as track and trend the performance of Valley-Wide as related to the access questions addressed above.

Region 5—Colorado Access

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two COA Region 5 PIPs: The *Well-Child Visits for Members 10–14 Years of Age* PIP and the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for COA Region 5 to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-5 summarizes COA Region 5's PIP close-out report.

Table 5-5—COA Region 5 FY 2019–2020 PIP Close-Out Summary

***Well-Child Visits for Members 10–14 Years of Age* PIP**	
Interventions	Ongoing, integrated well visit coding training for first year residents and attending physicians at the provider practice partner.
Successes	• Established strong partnership, data-sharing, and monthly reporting process with partner provider. • Partner provider established integrated and regularly reinforced well visit billing training for new residents. • Sustained improvement of well visit rates during the project.

Well-Child Visits for Members 10–14 Years of Age PIP	
Lessons Learned	The importance of clearly communicating PIP requirements/expectations—interventions and data collection—to the provider partner and obtaining buy-in/commitment from the provider partner up front. Importance of selecting interventions and intervention effectiveness data collection methods that are feasible for the provider partner.
***Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP**	
Interventions	Planned development and dissemination of provider education on qualifying follow-up services and appropriate billing practices focused on integrated primary/behavioral health sites.
Successes	Established a strong relationship and increased communication with partner provider.
Lessons Learned	The importance of involving administrators and clinicians in early PIP planning to help avoid billing and coding issues that may impact project performance, as was encountered in this project.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, COA Region 5 reported that it implemented the following interventions:

- As far as BH engagement goes, in September 2020, COA Region 5 expanded the established P4P Workgroup structure to begin holding a series of monthly workgroups with providers designed to address and improve on certain prioritized KPIs. The KPI Provider Workgroups were developed in an effort to drive performance for the Well Visit, Dental, and Behavioral Health Engagement KPIs. Although these workgroups focused on KPI improvement, the efforts around Behavioral Health Engagement will result in benefits that intersect with the Behavioral Health Incentive measures as the areas of care and services overlap in many metrics. These workgroups were designed as a space for collaborating and sharing best practices to drive performance and inform opportunities for the RAE to scale across the network. The benefits of these workgroups are multifold: COA Region 5 has identified barriers and areas of opportunity, gained significant knowledge on strengths and best practices, and strengthened provider alliances through these workgroups. Although final performance rates are pending for FY 2021, the momentum of the workgroups will be continued into FY 2022 to focus on metric improvement and provider collaboration.
- For the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* measure, COA Region 5 will continue to use its sophisticated internal ADT system to alert CMHCs of new admissions to inpatient care. This has allowed COA Region 5 to get involved in a timelier fashion to aid in disposition planning. IMDs have been on a value-based contract for seven-day follow up and, in most cases, have increased their rates. COA Region 5's dashboard helps alert it to those hospitals having difficulty. COA Region 5 then sets up meetings for the hospital and typical outpatient partners to aid in communication and process building.

- For the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure, COA Region 5 has worked with DHHA closely. They have changed their internal procedures and EHR in order to better capture their work.
- For the *Follow-Up After a Positive Depression Screen* measure, COA Region 5 has educated providers on screening and follow-up after a positive depression screen through multiple different venues. Provider workstreams have been examined with an emphasis on connecting PCMPs to behavioral health organizations to ensure referral streams so that members can get follow-up care if a BH specialists is not integrated within the PCMP practice.
- For the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* measure, COA Region 5's continued target has largely been with MAT/opioid use disorders, but COA Region 5 has since developed new programing—incentivizing engagement after a 3.2 WM visit has helped capture the other SUDs. Education sessions for all regional EDs in terms of SUD services and referrals also help with engagement.
- For the *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* measure, COA Region 5 worked with EDs and 3.2 WM facilities (as many times members go from ED to 3.2 WM) to educate and incentivize engagement. For the 3.2 WM value-based contracts, COA Region 5 has defined engagement as three treatment appointments within 30 days of discharge from WM.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement for coverage and authorization of services and grievances and appeals that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, COA Region 5 was required to:

- Ensure that RAE members 1) receive written notification of any decision to deny a service, including denial or partial denial of a claim; 2) that the NABD is written in a language that is easy for the member to understand; and 3) that the NABD includes all required content.
- Update policies to 1) include accurate time frames, including exceptions, for NABD mailings and 2) ensure members receive written notification of any denial of a service, including partial denials.

For Standard VI—Grievance and Appeal Systems, COA Region 5 was required to:

- Use both phone and written attempts to contact members to process grievances and, if the member cannot be reached, proceed with investigation based on information first given.
- Revise UM and claims payment procedures to clarify post-stabilization procedures.
- Implement a mechanism to ensure grievances that involve clinical issues are sent to individuals with clinical expertise for resolution.

- Ensure that grievance acknowledgement letters are sent within time frames; grievance resolution letters are sent within time frames and easy for the member to read; and, if grievance extension letters are sent, they include the member's right to file a grievance if the member disagrees with the extension.
- Ensure appeal resolution letters are easy for the member to read.
- Revise appeal resolution letters to ensure that only the information pertaining to the member's right to an SFH is included.
- Update policies to accurately depict a member's right to request continuation of benefits and associated timelines during appeals and SFHs.

COA Region 5 submitted its initial CAP in May 2020. Following Department approval, COA Region 5 successfully completed implementation of all planned interventions in November 2020.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and COA Region 5 developed targeted interventions to address high-priority failure modes. Over the course of three months, COA Region 5 monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, COA Region 5's scores reached over 90 percent accuracy for two of the five encounter data elements included in the QUIP. The two club house/drop-in encounter data elements showed improvement, but the three PEI encounter data elements remained under 90 percent accuracy. Accuracy within the club house/drop-in claim type achieved 100 percent in the first, second, and third months of the intervention period. The causes of inaccuracy that COA Region 5 reported for the PEI claim type included the clinician choosing or typing an incorrect procedure code; the EMR configuration not mapping to the appropriate CPT place of service; or the clinician selecting an incorrect procedure code, resulting in an incorrect modifier for the service billed. Key interventions included a provider CAP for additional training, verification of the place of service category prior to sending medical records from the provider to COA Region 5, and implementing a system to assure credentialed staff signatures and associated documentation were included in the medical record. COA Region 5 indicated continued follow-up with staff members and providers on these issues is planned to achieve improved accuracy rates.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, COA Region 5 reported engaging in the following QI initiatives:

- Continued to run internal rating measures examining customer service ratings by an external organization that provides timely feedback to customer service managers who can address ratings of associates and remedy issues immediately.
- Promoted and educated customer service and care management teams regarding the purpose of the survey for the first time to increase response rates and for more actionable feedback.
- The quality department presented to the Member Advisory Committee to share results and obtain feedback regarding *Health First Colorado Customer Service* and *Rating of Specialist Seen Most Often*.
- Administered a third iteration of the Customer Satisfaction Survey for continued and more up-to-date identification of improvement area opportunities.
- Introduced new collaborative efforts within customer service, care management, and provider relations to develop processes to increase information sharing for targeted secret shopper calls to 1) better understand member experience and 2) initiate interventions to improve experience.
- Implemented a member satisfaction survey on incoming calls in June 2020, which was administered by COA Region 5 customer service representatives. The member satisfaction survey is intended to solicit feedback from Health First Colorado members to ensure providers' excellent customer service and improve provider network issues. The Member Advisory Council was utilized to solicit feedback and input on the survey questions and direction. The first iteration of the survey focused on access and quality of care to understand members' experience in their physician's office or telehealth setting, and the subsequent iteration of the survey focused on health equity. This survey provided a valuable opportunity to hear from members and understand their care experience. The responses from the survey will improve how COA Region 5 interacts with and advocates for members by understanding their experiences. Within this survey, members' needs are also addressed by responding to dissatisfactory experiences with referral resources or additional coordination as needed at the time of the survey, which helps satisfy members' needs immediately. The customer service representatives have provided 220 referrals in real time to immediately assist and connect members with resources or services. Since its launch, nearly 2,000 surveys have been completed.
- Provider relations representatives collaborated with PCMH CAHPS practices to help improve response rates for more meaningful and actionable feedback.
- Monitored providers on access to care standards quarterly by conducting a series of calls to practices that mirror common member behavior to test the consistency of the provider behavior and availability of services offered to members. This activity checks for timeliness of appointment availability to validate compliance with standards as well as quality of calls. Targeted secret shopper calls in FY 2020–2021 Q3 were delivered to PCMH practices identified within the PCMH CAHPS participants to anticipate and correct any deficiencies prior to receiving PCMH CAHPS final reports in August/September. This was to compare results once the final report was delivered and to also receive more timely results on access to care and create interventions for improvement in a timely manner.

Region 6—Colorado Community Health Alliance

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two CCHA Region 6 PIPs: The *Well-Care Visits for Children Between 15–18 Years of Age* PIP and the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for CCHA Region 6 to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-6 summarizes CCHA Region 6's PIP close-out report.

Table 5-6—CCHA Region 6 FY 2019–2020 PIP Close-Out Summary

Improving Well-Care Visits for Children Between 15–18 Years of Age PIP	
Interventions	Targeted outreach by partner provider to encourage members to schedule and attend well visit appointments.
Successes	Improved outreach process and no-show policy by the partner provider to increase well-care visit rates.
Lessons Learned	• Barriers to internal claims data, due to SUD redaction, were uncovered by the health plan and shared with the Department.

Improving Well-Care Visits for Children Between 15–18 Years of Age PIP	
	• Partner provider learned the benefits of updating and communicating the no-show policy and offering incentives for completed preventive appointments for improving no-show rates.
***Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP**	
Interventions	• Provider training in best practices for facilitating follow-up care after positive depression screening. • Developed an EHR-based automated internal provider practice reminder system to facilitate depression screening.
Successes	• Established a successful partnership with the provider partner, including enhanced training and communication. • Developed improved tools, workflows, and processes to support provider partner's depression screening and follow-up efforts. • Increased behavioral health follow-up rates during the project.
Lessons Learned	• The need to facilitate standardization of consistent and reliable practices to gather accurate data in order to develop meaningful improvement processes was demonstrated by the challenges encountered with coding discrepancies between State metrics and provider coding practices. • The importance of allowing time at the start of the project for identification and resolution of data exchange and accuracy barriers.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, CCHA Region 6 reported that it implemented the following interventions:

- Implemented the SUD outreach process by having CCHA care coordinators and peer support specialists conduct outreach calls to members discharged from the ED for a SUD-related visit to support and facilitate outpatient aftercare appointment scheduling within seven days of discharge.
- Conducted clinical case reviews of members diagnosed with a SUD identified as high-utilizers of ED services to determine the drivers of high utilization and opportunities for diversion.
- Facilitated a partnership between Jefferson County Department of Human Services and Shiloh House to provide community-based BH assessments to children placed in foster care.
- Partnered with El Paso County Department of Human Services to implement a regular notification process of children placed in kinship and foster care to support identification and access to BH assessment services.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, CCHA R6 was required to complete five corrective actions:

- Update the definition of medical necessity to include all related criteria.
- Ensure, when appropriate, CCHA Region 6 outreaches providers for additional information needed for authorization decisions.
- Develop a mechanism to ensure 1) a written NABD is sent to members regarding denials, 2) the NABD includes language that is easy for the member to understand, 3) the letter is mailed within required time frames.

For Standard II—Access and Availability, CCHA Region 6 was required to complete one corrective action:

- Develop and implement a mechanism to conduct regular time and distance calculations to monitor State standards, specifically to ensure the member has two primary care medical provider choices within the member's ZIP Code or within maximum time and distance standards for the urban or rural geographic areas.

For Standard VI—Grievance and Appeal Systems, CCHA Region 6 was required to complete ten corrective actions:

- Develop a mechanism to ensure that 1) clinical grievances are reviewed and resolved by a staff person with appropriate clinical expertise, 2) grievances are received timely to ensure an acknowledgement letter is mailed within two working days of receipt, 3) grievance resolution letters are written in language that is easy for the member to understand and are mailed within 15 working days or the member receives a written extension if the grievance cannot be resolved within 15 working days, and 4) the resolution letter thoroughly addresses the member's specific complaint.
- Develop a mechanism to ensure that appeals are resolved within required time frames and resolutions are written in language that is easy for the member to understand.
- Develop an extension notice for grievances and appeals that includes required content (i.e., the reason for the extension, the right to file a grievance if the member disagrees with the extension) and improves the clarity of the language in the letter, and ensure the letters are sent to the members within the applicable time frames.
- Update policies to address 1) all content required in the appeal resolution letter, clarify continuation of benefits, ensure continuation of benefits is only included when applicable, and clarify how the member should request continued benefits; 2) time frames for continuation of benefits and criteria for requesting benefits; and 3) clarify how long benefits will continue.

- Update provider information to address inaccuracies or incomplete information regarding grievance and appeal information.

CCHA Region 6 submitted its initial CAP in March 2021. Following Department approval, CCHA Region 6 successfully completed implementation of all planned interventions in March 2021.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and CCHA Region 6 developed targeted interventions to address high-priority failure modes. Over the course of three months, CCHA Region 6 monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, CCHA Region 6 reached 100 percent compliance in three of three PEI encounter data elements, four of five club house/drop-in encounter data elements, and all seven residential encounter data elements. Notably, all but one encounter data element reached 100 percent compliance by the third month of interventions. CCHA Region 6 reported that the club house/drop-in service program category encounter data element inaccuracies may be due to a discrepancy in the benefit grid, incorrect documentation submitted for auditing, or a lack of minimum documentation for the code used in the service note. CCHA Region 6's QUIP included interventions such as reviewing and correcting the coding grid for discrepancies, updating the provider encounter data validation tip sheet to include specific guidance to ensure documentation is accurate and complete, and staff training regarding minimum documentation requirements in the service note. HSAG recommended CCHA Region 6 continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, CCHA Region 6 reported engaging in the following QI initiatives:

- CCHA Practice Transformation Coaches (PTCs) shared survey results with practices whose members were surveyed and worked with their QI teams to identify and implement interventions. Based on the categories with the lowest scores, CCHA Region 6 initiated improvement efforts around access to care, patient-centered communication, and coordinating medical care.
- PTCs tracked the third next available appointments quarterly to measure how many days it takes for members to get in for needed care. Practices out of compliance with contract standards were required to look at workflows, cycle times, and staff members involved with scheduling appointments and were then required to improve the time from the appointment request to the scheduled appointment time.
- PTCs encouraged practices to implement Patient and Family Advisory Councils (PFACs), in alignment with HCPF's Alternative Payment Model (APM) initiatives. The PFACs are used to review materials and gain feedback on how to effectively communicate with members and their families.
- PTCs worked with practices on improving/creating workflows for referrals to specialists to ensure that PCMPs receive follow-up information from the specialist.

Region 7—Colorado Community Health Alliance

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated two CCHA Region 7 PIPs: The *Well-Care Visits for Children Between 15–18 Years of Age* PIP and the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for both PIPs:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plans to close-out these two PIPs early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for CCHA Region 7 to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for each PIP including interventions tested, successes, and lessons learned. Table 5-7 summarizes CCHA Region 7's PIP close-out report.

Table 5-7—CCHA Region 7 FY 2019–2020 PIP Close-Out Summary

Improving Well-Care Visits for Children Between 15–18 Years of Age PIP	
Interventions	• Targeted outreach to 15–18-year-olds who were due for annual well-care visits. • Updated member recall workflow by the partner provider to better identify members for outreach.
Successes	• Member recall process improved by partner provider. • Increased understanding by partner provider of member attribution and their responsibility for those members.

Improving Well-Care Visits for Children Between 15–18 Years of Age PIP	
Lessons Learned	The importance of educating practices on regularly looking at attribution and empanelment, regardless of claims history, to ensure adequate resources are available to service all members.
Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening **PIP**	
Interventions	• Provider training in best practices for facilitating follow-up care after positive depression screening. • Developed an automated internal provider practice reminder to identify members due to depression screening. • Integration of the Patient Health Questionnaire-9 (PHQ-9) depression assessment tool into the provider partner's workflow.
Successes	• Developed improved tools, workflows, and processes to support provider partner's depression screening and follow-up efforts. • Increased behavioral health follow-up rates during the project.
Lessons Learned	• The importance of accurately estimating staff and resources needed for data collection and reporting. • The importance of adequate provider capacity to address performance improvement.

Validation of Performance Measures

To improve its BH rates from last year, CCHA Region 7 reported that it implemented the following interventions:

- Implemented the SUD outreach process by having CCHA care coordinators and peer support specialists conduct outreach calls to members discharged from the ED for a SUD-related visit to support and facilitate outpatient aftercare appointment scheduling within seven days of discharge.
- Conducted clinical case reviews of members diagnosed with a SUD identified as high-utilizers of ED services to determine the drivers of high utilization and opportunities for diversion.
- Facilitated a partnership between Jefferson County Department of Human Services and Shiloh House to provide community-based BH assessments to children placed in foster care.
- Partnered with El Paso County Department of Human Services to implement a regular notification process of children placed in kinship and foster care to support identification and access to BH assessment services.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, CCHA Region 7 was required to:

- Update the definition of medical necessity to include all related criteria.
- Ensure, when appropriate, CCHA Region 7 outreaches providers for additional information needed for authorization decisions.
- Develop a mechanism to ensure that the NABD 1) is sent to members on time and 2) includes language that is easy for the member to understand.

For Standard II—Access and Availability, CCHA Region 7 was required to:

- Develop and implement a mechanism to conduct regular time and distance calculations to monitor State standards, specifically to ensure the member has two primary care medical provider choices within the member's ZIP Code or within maximum time and distance standards for the urban or rural geographic areas.

For Standard VI—Grievance and Appeal Systems, CCHA Region 7 was required to:

- Develop a mechanism to ensure that 1) clinical grievances are reviewed and resolved by a staff person with appropriate clinical expertise, 2) grievance resolution letters are written in language that is easy for the member to understand and is mailed within 15 working days or the member receives a written extension if the grievance cannot be resolved within 15 working days, and 3) the resolution letter thoroughly addresses the member's specific complaint.
- Develop a mechanism to ensure that appeals are resolved within required time frames and resolutions are written in language that is easy for the member to understand.
- Develop an extension notice for grievances and appeals that includes required content (i.e., the reason for the extension, the right to file a grievance if the member disagrees with the extension) and improves the clarity of the language in the letter, and ensure the letters are sent to the members within the applicable time frames.
- Update policies to address 1) all content required in the appeal resolution letter, clarify continuation of benefits, ensure continuation of benefits is only included when applicable, and clarify how the member should request continued benefits; 2) time frames for continuation of benefits and criteria for requesting benefits; and 3) clarify how long benefits will continue.
- Update provider information to address inaccuracies or incomplete information regarding grievance and appeal information.

CCHA Region 7 submitted its initial CAP in March 2021. Following Department approval, CCHA Region 7 successfully completed implementation of all planned interventions in March 2021.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—RAE 411 Audit Over-Read

Results from the FY 2019–2020 411 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failure modes were then ranked in terms of priority and ability to impact data quality and CCHA Region 7 developed targeted interventions to address high-priority failure modes. Over the course of three months, CCHA Region 7 monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, CCHA Region 7 improved its three claim types with eight encounter data elements under 90 percent accuracy. CCHA Region 7 improved all eight encounter data elements to 100 percent accuracy by the end of the QUIP project. CCHA Region 7's QUIP interventions included reviewing the coding grid for discrepancies, updating the EMR to display lower level credentials, documenting activity start and stop times to assure correct unit calculations, ensuring admission and discharge date and time are clearly identified in supporting documentation and included in audit submissions, and ensuring admission and discharge dates are congruent with Colorado Client Assessment Record (CCAR) forms. HSAG recommended CCHA Region 7 continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

PCMH CAHPS

To improve member perceptions related to FY 2019–2020 PCMH CAHPS results, CCHA Region 7 reported engaging in the following QI initiatives:

- PTCs shared survey results with practices whose members were surveyed and worked with their QI teams to identify and implement interventions. Based on the categories with the lowest scores, CCHA Region 7 initiated improvement efforts around patient-centered communication and coordinating medical care.
- PTCs encouraged practices to implement PFACs, in alignment with HCPF's APM initiatives. The PFACs are used to review materials and gain feedback on how to effectively communicate with members and their families.
- PTCs worked with practices on improving/creating workflows for referrals to specialists to ensure that PCMPs receive follow-up information from the specialist.

Denver Health Medical Plan

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated the DHMP *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for DHMP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-8 summarizes DHMP's PIP close-out report.

Table 5-8—DHMP FY 2019–2020 *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP Close-Out Summary

Interventions	Partnering with school-based health centers (SBHCs) to outreach, schedule, and deliver well-care visits for adolescent members consented to receive care at SBHCs.
Successes	• Established partnership with SBHC leadership. • Developed communication system with community partners. • Developed EMR data extraction process to support automated text messages. • Improved adolescent well-care rates during the project.
Lessons Learned	• Partnership with SBHCs was critical to the success of the project and suggests continued partnership can lead to further improvement in outcomes for the adolescent member population.

Interventions	Partnering with school-based health centers (SBHCs) to outreach, schedule, and deliver well-care visits for adolescent members consented to receive care at SBHCs.
	• Technology development to support the intervention took longer than expected; going forward, additional time will be allowed for interventions relying on further development of technology.

HEDIS Measure Rates and Validation

To improve its HEDIS rates from the previous fiscal year, DHMP reported that it implemented the following interventions:

- Maintained and expanded active partnership and collaboration in QI workgroup activities with Ambulatory Care Services (ACS) on several QI interventions for 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 ambulatory care.
- Partnered in collaborative work process with QI Director of ACS and ACS QI staff members to build joint QI interventions, including shared data analytics.
- Continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS scores.
- Continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores.
- Increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Implemented focused member outreach to facilitate care transitions when acuity of need was identified.
- 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.
- Continued pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization.
- Developed and implemented enhanced patient education materials specific to chronic disease states and COVID-19-specific information.
- Conducted and reviewed the provider satisfaction survey. Incorporated data from ACS EMRs into supplemental files used for HEDIS reporting.
- Maintained reporting of quality of care concerns (QOCCs), and facilitated process improvements as identified during the QOCC review process.
- Developed clinical practice guidelines to cover the lifespan from infancy to geriatric.
- Streamlined clinical and preventive guidelines review and updating process.
- Increased physician involvement in the development of clinical guidelines.

- Continued development, review, and revision of policies and procedures annually through electronic tracking through the organization's transition to an updated system, PolicyStat.
- Maintained physician involvement within the QMC structure.
- For diabetes eye exams, an intervention to increase the percentage of members with diabetes receiving diabetic retinal exams has been in place for several years. The DHMP QI department tracks the number of members due for their diabetic eye exam in addition to those members who received an exam each month. This Microsoft SharePoint site also tracks the number of calls Eye Clinic care navigators completed and number of members with exams scheduled monthly and is shared with the Eye Clinic staff members. During FY 2019–2020, care navigators completed (defined as call where navigator is able to schedule member for a diabetic eye exam) 280 outreach calls to the eligible Medicaid population. As a result of the COVID-19 pandemic and the DHHA Eye Clinic moving to a new location, outreach for diabetic eye exams was suspended for most of FY 2020–2021. Limited outreach for Medicaid members resumed in spring of 2021 with plans to increase outreach as the year progresses; in addition, Denver Health has purchased new retinal cameras for all primary care clinics. Rollout of these cameras and associated trainings is currently taking place. Retinal cameras in all primary care sites will improve access for DHMP members and contribute to an overall improvement in exam rates. Given that DHMP Medicaid continues to be in the 10th percentile nationally (36.25 percent), this metric remains an area of opportunity for FY 2021–2022 and a priority collaboration between DHMP and ACS.
- For well-child visits, EPSDT, and immunizations, DHMP implemented the following:
  - Increased compliance with EPSDT related standards, with additional provider and member communication on services, provider communication about EPSDT requirements, and edits to related policy and procedures. Ongoing efforts continue for wraparound services outside of the health plan, and for tracking of referrals for services outside the health plan, by network providers. Improved the number of EPSDT services tracked at ACS, available by clinic and provider.
  - Healthy Hero Birthday Cards: In an effort to reach members ages 19 and under, DHMP QI and marketing sends annual birthday cards monthly to children ages 2 through 19 that provide a checklist with information on healthy eating, development, vaccines, and physical activity. 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. The card for Medicaid Choice members also included the contact information for Healthy Communities and how to schedule an appointment through Healthy Communities. For FY 2020–2021, DHMP mailed an average of 2,600 birthday cards a month to Medicaid Choice members.
  - With the termination of the Healthy Communities program, EPSDT outreach conducted by DHMP and population health Medicaid efforts conducted by the health plan will continue throughout FY 2021–2022 and remain a powerful way to identify members in need of screenings and services.
  - SBHCs: Denver Health Medicaid Choice members have access to 18 SBHCs within Denver Public elementary, middle, and high schools. SBHCs provide a variety of services such as well-child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral healthcare services. DHHA and DHMP continue to encourage eligible members

to access care through DHMP's network of SBHCs. This information is sent directly to member households in newsletters and is also available on the DHMP member website. In addition, the DHHA appointment center utilizes a process that alerts schedulers of an SBHC enrolled student, which will prompt them to schedule the child at an SBHC for their clinic needs. For DHMP's adolescent Medicaid population, collaboration with the Denver Public Schools' SBHCs to identify and see members for well-child visits during school hours has been highly successful in the past. As students return to in-person learning in the 2021–2022 school year, DHMP will be looking to restart collaboration with the SBHC team leads to get members who consent to be seen at an SBHC the care they need in a timely manner.

- For breast cancer screenings, monthly mammogram mailers are sent to members due for mammography. The mailer includes information on scheduling an appointment as well as a calendar for the women's mobile clinic. DHMP sent mammogram reminder mailers to 7,138 female Medicaid members between July 1, 2020, and June 30, 2021. Of the patients who received mailers between July 2020 and June 2021, 1,234 Medicaid members completed a mammogram during this time frame. Additionally, DHMP collaborated with ACS to ramp up communication after the peak of COVID-19 paused mammogram services.
- For asthma, the Asthma Work Group (AWG) and registered nurse (RN) line utilizes a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. Members are also informed about the need to make an asthma assessment appointment with their PCP if they have refilled their rescue medication without refilling the appropriate number of controller medications. ACS continues to utilize DHHA patient navigators (PNs) to conduct a follow-up phone call within 48 hours of discharge from the ED or an inpatient stay for pediatric members with an asthma-related concern. PNs are tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a transition of care flowsheet. Prior pharmacy refill and HEDIS data demonstrated that many asthmatics fill rescue asthma medications without filling the appropriate number of controller medications. The DHMP pharmacy team has directed more focus on the need to refill asthma controller medications on a consistent basis and began utilizing a pharmacy vendor tracking system in FY 2020–2021 to streamline this process. In Q4 of FY 2020–2021, the DHMP pharmacy team began working with DHHA ACS to provide lists of non-compliant members to their respective PCPs for intervention. This effort will continue into FY 2021–2022.
- For Access to Care measures, DHMP did the following:
  - Denver Health continues to operate 18 SBHCs that provide healthcare in an easy and convenient setting to all plan members who attend Denver Public Schools.
  - Several strategies were developed 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. Saturday morning hours for primary care at three locations have continued at the Montbello Health Center, Denver Health main campus, and at the Westside Family Health Center on Federal Boulevard.
  - In summer of 2021, the new DHHA Outpatient Medical Center (OMC) formally opened. The OMC is a 293,000 square-foot, state-of-the-art facility located just across from the main

hospital that will consolidate 20 specialty clinics, procedural areas, day surgery, and ancillary services into one convenient location, providing increased space and access in specialty care areas such as cardiology, orthopedics, outpatient behavioral health, and dental services. The OMC frees space on the main campus to continue growth in pediatric services and allows DHMP to increase the number of inpatient psychiatric beds. The modern facilities and state-of-the-art technology will increase capacity and allow DHMP to coordinate services more effectively, enabling providers to deliver better care for members.

- The opioid epidemic requires DHHA to envision a different care practice, one that fundamentally, not incrementally, changes DHMP's traditional model of MAT delivery. The Center for Addictions Medicine (CAM) continues to offer a full continuum of care that provides the Denver Health patient access to an array of substance treatment services. These services span a wide range of areas, including prevention and education, harm reduction, formal treatment and management of addiction disorders, along with post-treatment services, tools, and resources that support ongoing recovery.
- DHHA renovated the adult behavioral health facilities and increased the number of beds and living space for patients. Denver Health 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.
- Denver Health Medicaid Choice provides members with information on how to access the care they need through the provider directory, member handbook, and member newsletters. These materials provided information on how to obtain primary care, specialty care, after-hours care, emergency care, ancillary care, and hospital services. The Denver Health member handbook contains information on member benefits and how to access care within the DHMP network.
- New DHMP members are sent a welcome packet including their ID card and Quick Reference Guide. DHMP also provides orientation videos in English and Spanish on the website for members. These videos inform DHMP members about their benefits and provide information on how the plan works. DHMP staff members strive for excellence in care and service for all DHMP members in accordance with contract requirements.
- DHMP maintains a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine is capable of discussing the member's symptoms and concerns, assisting the member in understanding the urgency of their need and can assist with deciding the best course of action based on the urgency to see their PCP or going to the urgent care or ED. Additionally, the NurseLine nurses can write prescriptions for some illnesses and can also schedule a Dispatch Health visit.
- In early 2019 DHMP began contracting with Dispatch Health to support the membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. With the COVID-19 pandemic impacting hospital care, DHMP expanded the use of Dispatch Health to include skilled nursing facility (SNF) at home, hospital at home, and bridging services to assist in early discharges.
- Throughout the COVID-19 public health emergency, the ability of members to message their PCP and care team through MyChart has shown its value. MyChart is a user-friendly

application/website with multiple capabilities available to members to enhance and support their experience. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, review lab results, communicate directly with providers, and serves as a centralized location for tracking their health outcomes and programs. It was used this year to send mass messages about the availability of the COVID-19 vaccine as requirements changed rapidly. During the COVID-19 response, MyChart also became a telehealth urgent care option for members and was the main mechanism utilized in scheduling COVID-19 vaccinations.

- Due to COVID-19, many services transitioned to providing telehealth options.
- DHMP expanded its PCP footprint by contracting with STRIDE Community Health Center. The partnership adds 15 additional clinic locations (three of which have pharmacies on-site) and expanded options for DHMP's Medicaid members.
- DHMP was excited to announce in 2020 the grand opening of the Denver Health Sloan's Lake Primary Care Center, DHMP's 10th Community Health Center in the Denver metropolitan area. Providing the same leading services offered at DHMP's other locations, the new center is easily accessible for patients in Denver's Sloan's Lake, West Colfax, and Villa Park neighborhoods and opens in partnership with the Denver Housing Association, which provides senior housing located above the clinic.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, DHMP was required to complete one corrective action:

- Correct inaccuracies within the medical necessity denial letter (regarding dates, continuation of services, appeal, and SFH information).

For Standard II—Access and Availability, DHMP was required to complete two corrective actions:

- Develop a mechanism to track compliance with timely appointments (non-urgent symptomatic and post-hospitalization follow-up care).
- Develop a mechanism to monitor contracted providers to ensure compliance with timely access standards and implement CAPs if they fail to comply.

For Standard VI—Grievance and Appeal Systems, DHMP was required to complete six corrective actions:

- Communicate within member-specific communications that DHMP will assist the member with any procedural steps related to the appeal.
- Ensure that any notice to deny a request for an expedited resolution includes the reason for denying the expedited request.
- Ensure that appeal resolution letters are written in language that is easy for the member to understand.
- Clarify the appeal resolution letter to omit references to the appeal process (as it has been exhausted at this stage).
- Update policies, procedures, and related documents regarding the continued benefits process and time frames.
- Update the provider manual to include accurate details regarding grievances, appeals, and SFHs, including how to request continuation of benefits.

DHMP submitted its initial CAP in May 2020. Following Department approval, DHMP successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—MCO 412 Audit Over-Read

Results from the FY 2019–2020 412 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and MCO systems. These failure modes 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. Through these efforts, DHMP's interventions resulted in improvement in nine of the 13 encounter data elements targeted for the QUIP. DMHP's QUIP included sample auditing and other efforts to create educational forums for primary care physicians and contracted with an external auditing company to review audit results. DHMP described the addition of a provider website portal to make further resources available and exploring opportunities for compliance concepts and tracking efforts. Due to the variation in accuracy scores over the three-month sampling period, HSAG noted overall low to moderate likelihood of

improving outcomes based on the current interventions and recommended that DHMP continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

CAHPS Survey

To follow up on recommendations related to FY 2019–2020 CAHPS, DHMP reported engaging in the following QI initiatives:

- Improved communication with clinics about health plan QI initiatives, including education about health plan CAHPS scores.
- Increased member outreach through Acute Coronary Syndrome care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Implemented focused member outreach and care management to facilitate care transitions when acuity of need was identified.
- Developed and implemented enhanced patient education materials specific to chronic disease states and COVID-19 vaccination.
- The DHHA system is working to provide greater appointment availability by expanding capacity, hours of operation, and specialty services.
  - DHHA is working to expand access to care across numerous clinics and specialties.
  - The COVID-19 state of emergency has helped launch a new way of providing care using telemedicine. All providers are working toward use of virtual technology, in particular a new telemedicine urgent care is now fully functional.
  - To improve communication options, established patients are able to message their PCP and care team and schedule primary care visits through Epic MyChart.
  - The DHHA appointment center triages calls to escalate care when medically necessary.
  - There is a 24-hour NurseLine that is available for members when the appointment center is closed and when members describe experiencing specific symptoms.
  - Organizationally, there is an increased focus on improving consistent access to care through a delivery network that builds relationships, which results in increased satisfaction with the healthcare system and better health outcomes for the population.
  - To have increased insight into members' access to care, DHMP implemented a provider open shopper process. The Health Plan Services (HPS) team contacts providers to request appointment availability for different types of services. This process allows DHMP to monitor the network's ability to have timely access to services.
    - Efforts continue to improve HPS. The HPS team provides real-time training for staff members regarding member services call QI. The HPS team lead reviews calls from every staff member and performs on the spot evaluation and training. The team lead regularly performs sample audits of calls for each call representative. All HPS phone audit report results are presented and discussed bimonthly at the DHMP QMC.

- Worked with the member services department to develop a work plan that outlines the processes to effectively track member satisfaction. Each call with a member services representative concludes with the question, "Have I provided the help or information you needed today?" This is recorded in DHMP's care management software. Monitoring is conducted to ensure that member services representatives are asking the question. When members answer "no" to the above question, member services representatives track the reasons the member cites for not getting the help or information they needed. Tracking these reasons will assist in identifying process improvement and staff training opportunities.
- To understand the full spectrum of members' needs, DHMP has been performing a health needs assessment (HNA) of all new members. DHMP engaged a vendor to outreach to members to perform an initial HNA. The HNA engages the member with a series of health (physical and behavioral) and social determinants of health questions to identify the member's concerns and needs. The results of the HNA are communicated to the care coordination team, who follows up with the member. Based on the individual's needs, the care coordinator provides general information and resources (including community-based organizations), referrals, connection to a medical home, and general support. The HNA is mailed to all members and then is followed up with direct phone calls to the member.
- Modeling HCPF's risk stratification dashboard, DHMP has built a risk stratification tool that allows DHMP to monitor and analyze the member's health and needs. The tool allows DHMP to target specific conditions or issues (e.g., high number of ED visits) to outreach directly to members to provide education and resources.

Rocky Mountain Health Plans Medicaid Prime

Validation of Performance Improvement Projects

For FY 2019–2020, HSAG validated the RMHP Prime *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP. HSAG recommended the following as guidance for successful intervention evaluation and assessment of improvement during intervention testing for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for RMHP Prime to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-9 summarizes RMHP Prime's PIP close-out report.

Table 5-9—RMHP Prime FY 2019–2020 *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP Close-Out Summary

Interventions	In-house care management and referral to therapist.
Successes	Increased medication-assisted SUD treatment initiation rates and medication adherence during the project.
Lessons Learned	• The intake/initiation process requires more structure. • Members should receive access to peer support immediately upon intake/initiation. • COVID-19 prevented testing completion and impeded plans to sustain improvement or spread interventions.

HEDIS Measure Rates and Validation

To improve its HEDIS rates from the previous fiscal year, RMHP Prime reported that it implemented the following interventions:

- For the *Childhood Immunization Status* measure, mailing activities included:
  - New Baby Packet: Educational brochure mailed to the member's parent or guardian at 1 month of age. Includes education on child safety, recommended immunizations by age 2, and promotes child's health and safety through routine well-child checks.
  - Child's First Birthday: Educational brochure mailed at 12 months of age and includes education on why to immunize, how immunizations work, what happens if the child is not immunized, and a recommended immunization schedule from the Centers for Disease Control and Prevention (CDC).
  - Age 16 Months to 2-Year Immunizations Reminder: Incentive mailing brochure through which the member is eligible to receive a gift card upon completion and showing proof of receiving all CDC-recommended immunizations by the child's second birthday.
- For the *Childhood Immunization Status* measure, other activities included:
  - Monthly Interactive Voice Response (IVR) and Postcard Mailing: Children who missed an immunization between 6 and 18 months of age receive a postcard mailing and IVR call.
  - Member Newsletter: 2020 winter edition had information referencing Colorado immunization information system database. Included information on importance of well-child checks and immunizations.
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Childhood Immunization Status* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Immunizations for Adolescents* measure, mailing activities included:
  - Wellness That Rewards—Pre-Teen Wellness: Incentive mailing brochure sent to Members 10 to 13 years of age through which the member is eligible to receive a gift card upon completion of an annual wellness visit. This mailing includes educational content on immunizations for meningococcal meningitis, Tdap, HPV, and influenza.
- For the *Immunizations for Adolescents* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Immunizations for Adolescents* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Well-Child Visits in the First 30 Months of Life* measure, mailing activities included:
  - New Baby Packet: Well-Child Check Schedule: Educational brochure that includes recommended well-child visit schedules based on the Bright Futures and AAP guidelines.
  - Child's First Birthday: Educational brochure mailed to member's parent or guardian at one year of age during their birthday month. Includes information on health education topics, immunizations, and well-child visits.

  - Monthly IVR and postcard mailing for RMHP Prime members who are due for their 1-year-old well visit.
- For the *Well-Child Visits in the First 30 Months of Life* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Well-Child Visits in the First 30 Months of Life* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
  - RMHP Prime posted a social media campaign in May 2021 educating on the importance of members of all ages to have an annual wellness visit.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, mailings included:
  - Ages 3 to 17 (CHP+ and Prime): Incentive and educational mailing brochures sent to members 3 to 17 years of age and includes information on annual wellness visits, health education topics, healthy habits, immunization reminders, oral care, and growth and development.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, other activities included:
  - Monthly IVR and postcard mailing for RMHP Prime members who are due for their 1-year old well visit.
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Child and Adolescent Well-Care Visits* measure, mailing activities included:
  - Ages 3 to 21: Incentive and educational mailing brochures sent to members 3 to 21 years of age and includes information on annual wellness visits, health education topics, healthy habits, immunization reminders, oral care, behavioral health, growth and development, and avoidance of tobacco and vaping.
- For the *Child and Adolescent Well-Care Visits* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Child and Adolescent Well-Care Visits* is one of the focused measures in this group.
  - Completed educational webinar for providers to discuss coding practices in January 2021.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
  - RMHP Prime posted a social media campaign in May 2021 educating on the importance of members of all ages to have an annual wellness visit.
- For the *Cervical Cancer Screening* measure, mailing activities included:
  - Wellness That Rewards—Cervical Cancer Screening: Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of cervical cancer screening.

  - Email Campaign: Women's health screening email was sent on June 23, 2021, to female members 18 to 65 years of age educating on the covered benefit and importance of a yearly wellness exam, breast exam, and cervical cancer screening.

- For the *Cervical Cancer Screening* measure, other activities included:
  - On-hold telephone message recorded to play during the month of May 2021 to promote the importance of cervical cancer screening.
  - Maternity and Women's Care QIC subcommittee created in 2021 to focus on interventions for women's health. *Cervical Cancer Screening* is one of the focused measures in this group.
  - Website Provider and Member Tools: RMHP Prime Clinical Practice Guidelines are posted for reference. Added Women's Health Screening educational landing page on the RMHP Prime website.
- For the *Chlamydia Screening in Women* measure, mailing activities included:
  - Ages 18 to 21 Healthy Young Adult: Educational brochure mailed to men and women ages 18 to 21 years of age and includes preventive health recommendations for annual chlamydia screening in sexually active women.
- For the *Chlamydia Screening in Women* measure, other activities included:
  - Maternity and Women's Care QIC subcommittee created in 2021 to focus on interventions for women's health. *Chlamydia Screening in Women* is one of the focused measures in this group.
  - A deep dive focus group examined the root cause analysis of chlamydia rates.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
  - Website Provider and Member Tools: Added Women's Health Screening educational landing page on the RMHP Prime website.
- For the *Breast Cancer Screening* measure, mailing activities included:
  - Wellness That Rewards—Breast Cancer Screening: Incentive mailing brochure sent to female members 50 to 74 years of age through which the member is eligible to receive a gift card upon completion of breast cancer screening.
  - Email campaign: Women's health screening email was sent on June 23, 2021, to female members 18 to 65 years of age educating on the covered benefit and importance of a yearly wellness exam, breast exam, and cervical cancer screening.
- For the *Breast Cancer Screening* measure, other activities included:
  - On-hold telephone message promoting breast cancer awareness throughout the month of October 2020 to increase member knowledge on the importance of breast cancer screening was placed on member customer service lines for all lines of business.
  - A Provider Gap Report was sent in October 2020 to providers listing members who were missing breast cancer screening for collaboration on completion of breast cancer screenings.
  - Created Maternity and Women's Care QIC subcommittee in 2021 and *Breast Cancer Screening* is one of the focused measures in this group.

  - Website Provider and Member Tools: RMHP Prime Clinical Practice Guidelines are posted for reference, added Women's Health Screening educational landing page on the RMHP Prime website, and a blog promoting education and awareness about breast cancer screenings.
- For the *Adults' Access to Preventive/Ambulatory Health Services* measure, activities included:
  - EasyCare Colorado is available to RMHP Prime members, free of charge. It is a text-based virtual care platform that lets members connect with a real doctor in seconds 24 hours a day, seven days a week.
- For the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, activities included:
  - Created Pediatrics Team QIC subcommittee in June 2021 and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Comprehensive Diabetes Care* measure, mailing activities included:
  - Wellness That Rewards—Comprehensive Diabetes Care: Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of their diabetes health exams with their healthcare provider.
  - Wellness That Rewards—Diabetes HbA1c Test: Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of their diabetes HbA1c test.
  - Wellness That Rewards—Diabetes Eye Exam: Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of their diabetes eye exam.
- For the *Comprehensive Diabetes Care* measure, other activities included:
  - RMHP Prime Care Management Department's chronic disease program for diabetes. Connects members to a PCP if they do not have a medical home, identifies gaps in care, addresses social determinants of health needs, and provides care coordination.
  - Pharmacy Medication Adherence Program: Pharmacy member outreach occurred through the Medication Adherence Program for diabetic members not compliant with their medication. Follow-up mailings were sent to the member and to their provider.
  - In October and December of 2020, the care management department performed phone outreach to members with an HbA1c greater than 9 percent, and/or those with no HbA1c test in 2020 to encourage them to complete the test.
  - Eliza IVR phone outreach to members with diabetes gaps in care occurred in 2020 to engage members in completion of all recommended diabetic tests/screenings and to assist members with scheduling of appointments.
  - Gap reports were sent in October 2020 to inform providers of members with no HbA1c test in 2020 or an HbA1c greater than 9 percent to provide a reminder on the importance of the member getting recommended diabetes screenings.
  - Practice Transformation Provider Education: A Diabetes Toolkit was developed for distribution to practices that assists with best practices around care coordination and care

management of diabetic populations. Diabetes management was the topic at provided learning collaboratives and webinar series.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
  - RMHP Prime posted a social media campaign in June 2021 educating on the importance of regular check-ups with a primary care provider for members with diabetes to effectively manage their diabetes.
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Comprehensive Diabetes Care* is one of the focused measures in this group
- For the *Statin Therapy for Patients With Diabetes* measure, activities included:
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Statin Therapy for Patients With Diabetes* is one of the focused measures in this group.
- For the *Statin Therapy for Patients With Cardiovascular Disease* measure, activities included:
  - Note that, some of these sub-measures had small denominators.
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Statin Therapy for Patients With Cardiovascular Disease* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* measure, activities included:
  - RMHP Prime care managers reach out to members within 48 hours of discharge from a mental health inpatient facility.
- For the *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* measure, activities included:
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* is one of the focused measures in this group.
- For the *Asthma Medication Ratio* measure, activities included:
  - The RMHP Prime care management department deployed a chronic disease program for asthma in children from July 1, 2020, through October 1, 2020.
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Asthma Medication Ratio* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Prime Clinical Practice Guidelines are posted for reference.
- For the *Pharmacotherapy Management of COPD Exacerbation* measure, activities included:
  - The RMHP Prime care management department deployed a chronic disease program for COPD members in December 2020.

  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Pharmacotherapy Management of COPD Exacerbation* is one of the focused measures in this group.
- For the *Use of Opioids From Multiple Providers* and *Risk of Continued Opioid Use* measures, activities included:
  - Created Behavioral/SUD QIC subcommittee in 2021 and both *Use of Opioids From Multiple Providers* and *Risk of Continued Opioid Use* are focused measures in this group.
  - Treating opioid use disorders was a topic in the February newsletter and also included additional information and resource links around this topic.

Assessment of Compliance With Medicaid Managed Care Regulations

For the three standards reviewed in FY 2019–2020 (Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

For Standard I—Coverage and Authorization of Services, RMHP Prime was required to complete three required corrective actions:

- Correct UM policies to address the 10-calendar-day time frame for standard authorization decisions.
- Correct UM policies to address 14-calendar-day extensions for both standard and expedited authorization decisions.
- Ensure NABDs are written in a manner that is easy for a member to understand (i.e., at or below the sixth grade reading level).

For Standard VI—Grievance and Appeal Systems, RMHP Prime was required to complete five required corrective actions:

- Develop a mechanism to ensure grievances regarding treatment are reviewed by someone with clinical expertise.
- Ensure each grievance is thoroughly addressed.
- Communicate the appeal resolution and reason for the decision in member-friendly language.
- Update policies to accurately reflect continuation of benefits information (two required actions).

RMHP Prime submitted its initial CAP in June 2020. Following Department approval, RMHP Prime successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV reporting throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

Encounter Data Validation—MCO 412 Audit Over-Read

Results from the FY 2019–2020 412 EDV were used for a QUIP follow-up activity in FY 2020–2021. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and MCO systems. These failure modes 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, 13 of the 15 encounter data elements showed an increase in accurate scores. RMHP Prime's QUIP identified several root causes, such as the lack of a formal process for submission of medical records or record submission is outsourced to another organization; the EHR does not auto-populate certain information, such as patient, date, or provider identifiers, on each page of the medical record; the rendering qualified provider was not up to date with billing signature requirements; or the EHR software has signature issues. RMHP Prime indicated that the resolution to this issue is a longer-term goal, spanning beyond the scope of the QUIP project. However, RMHP Prime has identified training needs and effective mechanisms to sustain documentation improvements through ongoing record reviews, professional network training, and continued attendance at facility meetings to support education and best practice documentation. RMHP Prime was able to achieve a sustained improvement in all accuracy scores from month two to three. RMHP Prime expressed an expectation for sustainability of the improvement achieved in encounter data submission accuracy for these encounter data types.

CAHPS Survey

To follow up on recommendations related to FY 2019–2020 CAHPS, RMHP Prime reported engaging in the following QI initiatives:

- Customer service implemented a process to notify provider relations when it is informed by members that a healthcare provider is not accepting new patients, or is requiring applications for acceptance. Provider relations will follow up with the provider to investigate and address the member's concern.
- During member welcome calls, customer service educates members on the importance of having a primary care relationship with a PCP. Customer service asks the member if they have a PCP and, if so, if they have an appointment coming up. If the member does not have a PCP, customer service offers to help the member find one and connects them with the office to schedule an appointment.

- A CAHPS educational video series was discussed during value-based contracting office hours with practices. In addition, the videos are available on the RMHP Prime website. The goal was to increase provider awareness of the CAHPS survey and encourage PCPs to deliver high-quality patient-centered care.
- A Podcast series is available on Podbean and the RMHP Prime website. It includes interviews with healthcare professionals with tips about improving communication and building patient relationships.
- Member experience topics were included in newsletter articles, learning collaborative events, and the webinar series. Topics included leadership training, behavioral health skills training, care management training, medical assistant skills and training, and telehealth visits.

Appendix A. MCO Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for HEDIS MY 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS MY 2020 hybrid rate.

Table A-1—HEDIS MY 2020 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	83.36%	87.10%	25th–49th
Postpartum Care	69.22%	74.21%	25th–49th

**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 MY 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS MY 2020 hybrid rate.

Table A-2—HEDIS MY 2020 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	5.83%	75.74%	25th–49th
Counseling for Nutrition—Total	20.42%	77.87%	50th–74th
Counseling for Physical Activity—Total	0.00%	72.34%	50th–74th
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	56.65%	91.00%	50th–74th
Postpartum Care	32.89%	85.64%	≥90th
Preventive Screening			
Cervical Cancer Screening			
Cervical Cancer Screening	40.27%	52.01%	10th–24th
Living With Illness			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	86.61%	92.77%	≥90th
*HbA1c Poor Control (>9.0%)**	71.37%	25.94%	≥90th
HbA1c Control (<8.0%)	23.85%	60.10%	75th–89th

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Eye Exam (Retinal) Performed	48.57%	59.60%	50th–74th
Blood Pressure Control (<140/90 mm Hg)	0.13%	75.31%	—

**For this indicator, a lower rate indicates better performance.*
— Indicates that NCQA recommended a break in trending; therefore, comparisons to benchmarks are not performed.