COLORADO

Department of Health Care Policy & Financing

FY 2021–2022 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

November 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acknowledgments and Copyrights

1. Executive Summary

Background

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, required 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" or managed care entities [MCEs]) 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 of, timeliness of, and access to services provided by the contracted health plans. Revisions to the regulations articulated in the BBA were released in May 2016 and again in November 2020. The final Medicaid and CHIP managed care regulations are provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438. To meet the requirements for EQR, the Colorado Department of Health Care Policy & Financing (the Department) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

HSAG recognizes that EQR-related activities in fiscal year (FY) 2020–2021 and, to a lesser extent, FY 2021–2022 were conducted during the unprecedented coronavirus disease 2019 (COVID-19) pandemic; therefore, results and recommendations, particularly in the access to care domain for both FY 2020–2021 and FY 2021–2022, should be considered with caution. Regardless, while some health plans experienced lower scores across domains of care across these two reporting years, Colorado's Medicaid health plans also found innovative and creative ways to address barriers and continued to provide services 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 (PCPs) and capitated behavioral health (BH) providers

to ensure access to both BH and primary care for Medicaid members through one accountable entity per region. 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 2021–2022 was the fourth 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 2021–2022. Colorado does not exempt any of its RAEs or Medicaid 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 Colorado's MCEs

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 2021–2022 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—RAEs only (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 only (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' and MCOs' compliance with State and federal managed care regulations and related Department contract requirements. HSAG assessed compliance through review of four 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 over-read (Protocol 5).** HSAG reviewed a sample of BH encounter data to ensure that medical record documentation supported the RAEs' (which includes DHMP) encounter data submissions to the Department. HSAG sampled the records reviewed by each RAE and DHMP and conducted an over-read to validate the RAEs' EDV results.
- **EDV—MCO 412 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 6, 2022.

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.

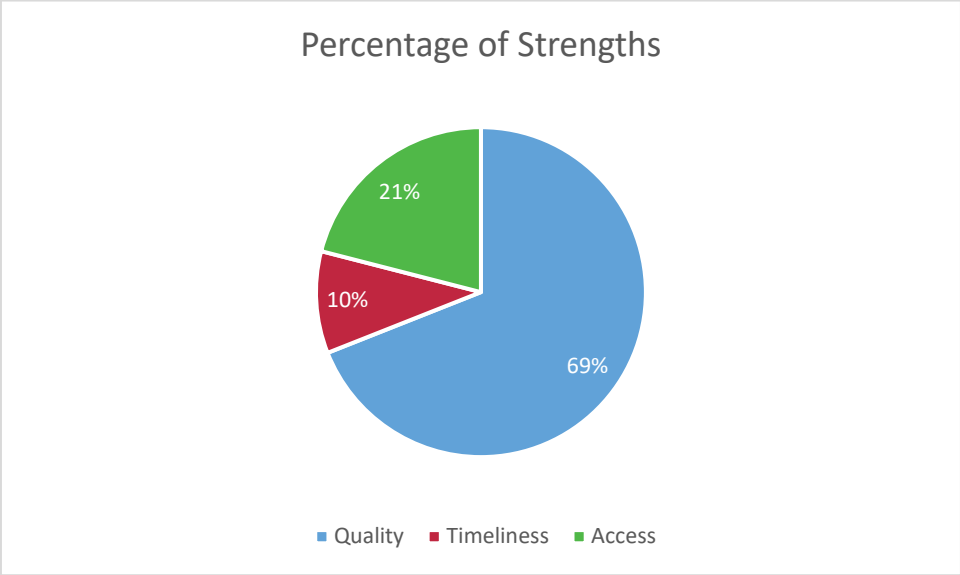
- **CAHPS surveys—RAEs (Protocol 6).** HSAG annually administers the CAHPS 5.1H Adult and Child Medicaid Health Plan Survey to adult and child Medicaid members enrolled in the seven RAEs. HSAG includes adult and child survey results in this report.
- **CAHPS surveys—MCOs (Protocol 6).** Each MCO was responsible for conducting a CAHPS survey of its members and forwarding the results to HSAG for inclusion in this report.
- **Quality Improvement Plans (QUIPs)—MCOs and RAEs (Protocol 8).** Following the 411 and 412 audits, each health plan is required to design a QUIP to target findings of low encounter data accuracy (under 90 percent) within its own service coding accuracy reports. HSAG tracks and monitors each QUIP to ensure the improvement interventions are appropriately designed and outcomes achieve increased accuracy in encounter data submissions.
- **Mental Health Parity (MHP) Audits—MCOs and RAEs (Protocol 9).** HSAG annually monitors the MCEs to ensure continued compliance with findings articulated in the Department's MHP analysis. Activities include an annual audit of each MCE's utilization management (UM) program procedures and denial determinations to ensure compliance with federal and State MHP regulations.
- **Quality of Care Concern (QOCC) Audit—MCOs and RAEs (Protocol 9).** HSAG annually monitors the MCEs to evaluate policies, procedures, and processes related to processing and investigating QOCCs and for reporting such concerns to the Department.
- **External Quality Review (EQR) Dashboard—MCOs and RAEs (Protocol 9).** HSAG designed the EQR Dashboard to allow the Department to monitor and track the MCEs' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, MHP Audit compliance scores, and PIPs.

Summary of FY 2021–2022 Statewide Performance by External Quality Review Activity

RAEs Providing Services Under Colorado's Accountable Care Collaborative Program

Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted during FY 2021–2022.

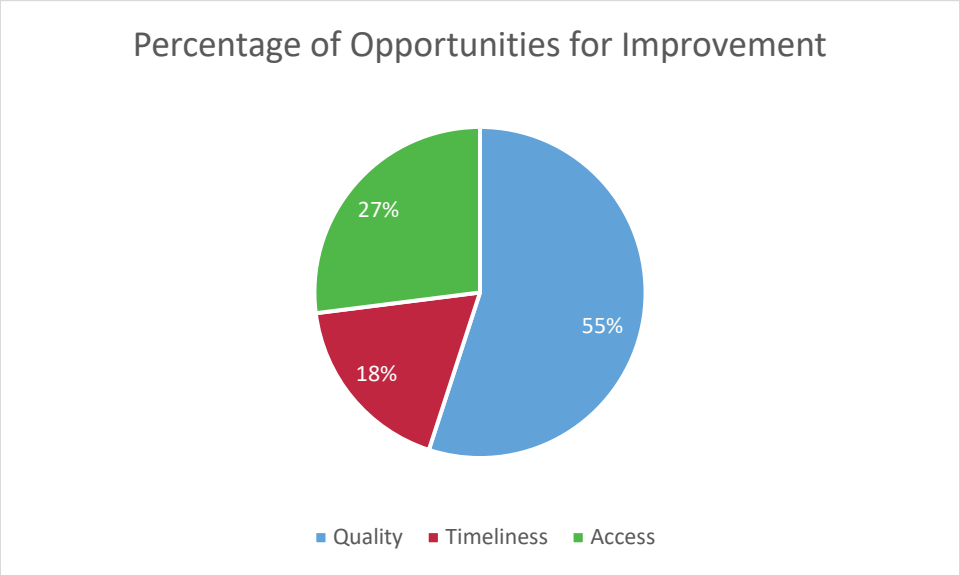
Figure 1-1—Percentage of Strengths by Care Domain*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 1-2 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality of, timeliness of, and access to care and services provided by the RAEs.

Figure 1-2—Percentage of Opportunities for Improvement by Care Domain*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are statewide findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Table 1-2 displays the results of the FY 2021–2022 PIP validations and summarizes how far through the four modules of the rapid-cycle PIP process each RAE progressed.

Table 1-2—FY 2021–2022 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, Module 2, and Module 3*	NA
Region 2—NHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Region 3—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Region 4—HCI	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Region 5—COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Region 6—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Region 7—CCHA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2021–2022 validation cycle.*

During the FY 2021–2022 validation cycle, the RAEs continued ongoing PIPs, submitting Module 3 of the rapid-cycle PIP process for validation. In Module 3, the RAE defines the plan for the intervention to be tested. During FY 2021–2022, HSAG provided technical assistance and feedback to the RAEs on the intervention testing plan, including the intervention effectiveness measure and data collection process. The RAEs continued testing interventions for the PIP until the end of the fiscal year. In FY 2022–2023, the RAEs will submit the final rapid-cycle PIP module, Module 4—PIP Conclusions, for validation and will report the final results, conclusions, and lessons learned for the PIPs.

Statewide Strengths Related to Validation of PIPs for the RAEs

Based on the PIP validation activities completed in FY 2021–2022, HSAG found the following strengths:

- All RAEs selected PIP interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim goals for improvement.
- All RAEs initiated testing of PIP interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through Plan-Do-Study-Act (PDSA) cycles.

Statewide Opportunities for Improvement and Recommendations Related to Validation of PIPs for the RAEs

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. All RAEs effectively addressed all Module 3 PIP validation criteria.

To support successful progression of the PIPs in the next fiscal year, HSAG recommends the following:

- The RAEs should collect complete and accurate intervention effectiveness data for each tested intervention. Each RAE should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- The RAEs should ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, the RAEs should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, the RAEs should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the RAEs should document which interventions had the greatest impact.

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 member enrollment and verifying member eligibility, processing claims and encounters, and data integration for measure calculation.

Performance Measure Results

Table 1-3 shows the measurement year (MY) 2021 performance measure statewide average rates (calculated and validated in FY 2021–2022) and the corresponding incentive performance targets that were developed by the Department for the RAEs. The performance targets were developed using the top performer from the prior year and adding 10 percent to that rate.

Table 1-3—Statewide Averages for the RAEs

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	MY 2021 Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment				
Engagement in Outpatient SUD Treatment	47.64%	38.84%	46.28%	51.00%
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%	52.99%	87.58%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for SUD				
Follow-Up Within 7 Days of an ED Visit for SUD	34.98%	36.02%	33.27%	48.22%
Follow-Up After a Positive Depression Screen				
Follow-Up After a Positive Depression Screen	50.16%	51.94%	62.88%	67.93%
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%	22.04%	30.56%

Statewide Strengths Related to BH Performance Measures for the RAEs

The following statewide average rates improved from the previous year:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

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

The following rates were below the Department-determined performance target for the applicable measure:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

To address these low rates, HSAG recommends:

- The Department work with the RAEs to identify interdependencies across measures.
- The Department create a RAE workgroup where best practices can be shared.
- The RAEs convene monthly meetings to monitor interventions and progress toward meeting established goals.

Assessment of Compliance With Medicaid Managed Care Regulations

Table 1-4 displays the statewide average compliance monitoring results and the year that each standard area was reviewed. HSAG reviews one third of the standards each year. The RAEs began their contracts with the Department in FY 2018–2019, and FY 2021–2022 was the fourth year of RAE operations. Therefore, comparison scores exist for only one third of the standards. For individual RAE scores and findings, see Section 3. For RAE-level comparison of scores for FY 2021–2022 standards, see Section 4, Table 4-4.

Table 1-4—Compliance With Regulations—Statewide Performance for the Seven RAEs Included in the ACC Program

Standard and Applicable Review Years*	Initial Statewide Average	Most Recent 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; 2021–2022)	**95%**	**97%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**98%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**92%**	**89%**
Standard VI—Grievance and Appeal Systems (2019–2020)	79%	
Standard VII—Provider 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, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**88%**	**92%**

**Bold text indicates standards that HSAG reviewed during FY 2021–2022.*

***Grey shading indicates standards for which no previous comparison results are available.*

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

In FY 2021–2022, the fourth year of RAE operations, comparisons across the four standards reviewed showed improvement in compliance scores in three of the four standards, indicating a strong understanding of most federal and State regulations among the RAEs.

Statewide Strengths Related to Compliance With Regulations for the RAEs

Through review of the four standards, HSAG found the following statewide strengths among the RAEs:

- The highest scoring standard was Standard IV—Member Rights, Protections, and Confidentiality, in which all seven RAEs scored 100 percent. Each RAE submitted and described detailed policies, procedures, and provider and member informational materials that outlined member rights and protections, and staff members described methods of acting on feedback, if needed, to address member rights issues.
- Related to Standard III—Coordination and Continuity of Care, the RAEs engaged with multiple internal departments such as care coordination, UM, care management, and customer service to support efforts in aiding the member with BH and PH care.
- Related to Standard III—Coordination and Continuity of Care, all RAEs, to some extent, delegated care coordination activities to accountable providers, provider groups, or care coordination entities within the region. Most RAEs implemented comprehensive policies and procedures to serve all members including those with complex, high-risk, and special health care needs (SHCN).
- Multiple RAEs achieved 100 percent compliance for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Each RAE made best efforts using various methods to inform eligible members about Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) services.
- Many RAEs demonstrated robust processes to ensure adherence with Standard V—Member Information Requirements, such as posting machine-readable documents on websites, using plain language at the sixth-grade reading level, and ensuring availability of translated materials and auxiliary aids.

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

HSAG found the following opportunities for improvement:

- Some RAEs did not send any written follow-up information to members after care coordination outreach calls to engage members identified as needing care coordination.
- Two RAEs did not have clearly delineated roles, responsibilities, or monitoring mechanisms for care coordination delegates, and some RAEs did not outline details for care coordination delegates regarding expected care coordination outreach methods for high-risk members.
- Some RAEs provided member informational materials that were above a sixth-grade reading level and other RAE websites contained Web accessibility issues (i.e., noncompliance with Section 508). Many critical materials did not include all required tagline language, in English and in Spanish, and in a conspicuously visible font size.

- The RAEs that utilized the Department's member welcome letter did not send new members all required information following enrollment, specifically the RAE's website address.

To address these opportunities for improvement, HSAG recommends that the Department:

- Encourage the RAEs to consider sending a follow-up letter with care coordination program information to each member identified as needing care coordination.
- Clarify expectations regarding roles, responsibilities, and monitoring for providers and entities involved in care coordination delegation models.
- Develop template materials, where possible, and encourage the use of the CMS *Toolkit for Making Written Material Clear and Effective*.
- Ensure the updated member welcome letter includes all required components of member information, specifically each RAE's website address.

Validation of Network Adequacy

Statewide Strengths Related to Validation of Network Adequacy

Based on network adequacy validation (NAV) activities completed in FY 2021–2022, HSAG found the following statewide strengths:

- All RAEs participated in the quarterly NAV analysis.
- The Department demonstrated significant growth in its oversight of the RAEs' networks through the development and implementation of standardized quarterly network adequacy reporting materials.
- In the FY 2021–2022 time and distance analysis, the RAEs exhibited improvements in member access compared to the same activity performed in FY 2020–2021. Across RAEs, urbanicities, and practitioner network categories, there were notable improvements in the percentage of network requirements assessed for which the RAEs were meeting the Department's 100 percent standard, particularly for the PH primary care provider type.
- The RAEs exhibited substantial increases in the percentage of requirements with 100 percent access for the PH primary care provider type. In both frontier and rural counties, the percentage of requirements with 100 percent access increased.

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

HSAG found the following opportunities for improvement.

- Among the RAEs, there were substantial decreases in the number of network requirements that met the standards in frontier and rural counties, with smaller decreases in the percentage of standards met in urban counties. It is important to note that this decrease may be in part due to a change in the BH minimum network requirements for DHMP.[1-2]
- The MCEs' network data quality could be further enhanced by validating against the Department's *interChange* data[1-3] to confirm RAE practitioner network National Provider Identifiers (NPIs), practitioner identification values, practitioner addresses, and taxonomy codes to determine the extent to which each RAE's network aligns with the practitioner/practice site/entities enrolled in *interChange*.

To address these opportunities for improvement HSAG recommends:

- The Department consider continuing the development and implementation of formal network exception policy and request templates to address network adequacy concerns in circumstances in which the RAEs are persistently unable to meet applicable Colorado NAV time and distance standards.
- The Department consider the extent to which the RAEs offer alternate service delivery mechanisms to ensure members' access to care when provider shortages or other issues create barriers to meeting minimum network requirements in certain geographic areas and/or network provider categories.
- The Department consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population needs. Although current network standards developed by the Department were designed to assess the number of specific provider types located within given driving times and distances from members, the adequacy of the networks to address specific population needs may be more comprehensively assessed by including and cross-referencing encounter data to assess actual utilization patterns.

[1-2] NAV results for DHMP's minimum BH network requirements are included in the RAEs' aggregated BH results because DHMP is contracted to provide behavioral healthcare services to its members, similar to the RAEs' contractual requirements. All Medicaid MCO PH aggregate results are included in the Medicaid MCO section.

[1-3] *interChange* is the Department's Medicaid Management Information System (MMIS). All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs. While *interChange* offers a direct alignment with the Network Crosswalk for selected network categories, not all network categories are directly identified from the *interChange* data fields.

Encounter Data Validation—RAE 411 Over-Read

Table 1-5 presents the RAEs' (which includes DHMP's 411 results) self-reported encounter data service coding accuracy results by BH service category and validated data element.

Table 1-5—RAEs' FY 2021–2022 Aggregated, Self-Reported EDV Results by Data Element and BH Service Category

Data Element	Inpatient Services (1,096 Cases)	Psychotherapy Services (1,096 Cases)	Residential Services (1,096 Cases)
Procedure Code	NA	82.8%	90.0%
Principal Surgical Procedure Code	97.3%	NA	NA
Diagnosis Code	85.8%	86.7%	89.5%
Place of Service	NA	75.1%	85.6%
Service Category Modifier	NA	83.4%	89.6%
Units	NA	90.9%	90.8%
Revenue Code	93.5%	NA	NA
Discharge Status	88.5%	NA	NA
Service Start Date	94.3%	92.3%	91.3%
Service End Date	96.1%	92.4%	91.1%
Population	NA	92.2%	91.4%
Duration	NA	88.6%	91.1%
Staff Requirement	NA	88.3%	90.5%

**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 1-6 presents, by BH service category, the percentage of cases in which HSAG's over-read results agreed with the RAEs' (which includes DHMP's 411 results) aggregated EDV results for each of the validated data elements.

Table 1-6—FY 2021–2022 Statewide Aggregated Encounter Over-Read Agreement Results for RAEs by BH Service Category

BH Service Category	Inpatient Services (80 Over-Read Cases)	Psychotherapy Services (80 Over-Read Cases)	Residential Services (80 Over-Read Cases)
Procedure Code	NA	98.8%	93.8%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	98.8%	95.0%	93.8%
Place of Service	NA	93.8%	95.0%
Service Category Modifier	NA	97.5%	93.8%
Units	NA	NA	95.0%
Revenue Code	100%	NA	NA
Discharge Status	98.8%	NA	NA
Service Start Date	95.0%	96.3%	95.0%
Service End Date	96.3%	96.3%	95.0%
Population	NA	97.5%	95.0%
Duration	NA	97.5%	95.0%
Staff Requirement	NA	95.0%	95.0%

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

Statewide Strengths Related to RAE 411 EDV Over-Read

Based on HSAG's overread of the RAEs' self-reported EDV results, HSAG found the following statewide strengths:

- 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.
- For inpatient services, the agreement rate for validation elements among the RAEs and DHMP ranged from 95.0 percent to 100.0 percent for over-read results and 85.8 percent to 97.3 percent for service coding accuracy results.
- HSAG's over-read aggregate percentage was more than 93.8 percent across data elements for psychotherapy services claims and higher than the aggregate rates for service coding accuracy results.
- For residential services, the aggregate percentages for both the over-read results and the service coding accuracy results were high across all data elements, ranging from 93.8 percent to

95.0 percent for over-read results and 85.6 percent to 91.4 percent for service coding accuracy results.

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

HSAG found the following opportunities for improvement:

- The RAEs' and DHMP's self-reported service coding accuracy results reflected more than 90.0 percent agreement for all data elements except two data elements in inpatient services cases, six data elements in psychotherapy services cases, and three data elements in residential services cases.

To address these opportunities for improvement, HSAG recommends:

- The Department verify that the RAEs and DHMP continue to evaluate and enhance their internal processes for ongoing encounter data monitoring and use the Department's annual RAE 411 EDV study as a focused mechanism for evaluating the quality and completeness of BH encounter data.

CAHPS Surveys

Table 1-7 shows the FY 2021–2022 Colorado RAE aggregate (i.e., statewide average) adult CAHPS results.

Table 1-7—FY 2021–2022 Adult Statewide CAHPS Results for RAEs

Measure	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	55.2% ↓
Rating of All Health Care	56.5%
Rating of Personal Doctor	66.2%
Rating of Specialist Seen Most Often	69.2%
Getting Needed Care	80.9%
Getting Care Quickly	78.9%
How Well Doctors Communicate	91.3%
Customer Service	86.7%

↑ *Indicates the FY 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

Table 1-8 shows the FY 2021–2022 Colorado RAE aggregate (i.e., statewide average) child CAHPS results.

Table 1-8—FY 2021–2022 Child Statewide CAHPS Results for RAEs

Measure	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	70.8%
Rating of All Health Care	65.1% ↓
Rating of Personal Doctor	76.1%
Rating of Specialist Seen Most Often	70.9%
Getting Needed Care	80.2% ↓
Getting Care Quickly	84.9%
How Well Doctors Communicate	93.6%
Customer Service	86.0%

↑ *Indicates the FY 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

Statewide Strengths Related to CAHPS Surveys

Adult

For the adult population, the following measure's FY 2021–2022 score was higher, although not statistically significantly, than the 2021 NCQA national average:

- *Rating of Specialist Seen Most Often*

Child

For the child population, none of the measures' FY 2021–2022 scores were higher than the 2021 NCQA national averages.

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

Adult

For the adult population, the following measure's FY 2021–2022 score was statistically significantly lower than the 2021 NCQA national average:

- *Rating of Health Plan*

Child

For the child population, the following measures' FY 2021–2022 scores were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*

To address these low CAHPS scores, HSAG recommends:

- 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 CAHPS results for FY 2021–2022, refer to the Medicaid aggregate CAHPS report found on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

Quality Improvement Plans

Table 1-9 presents the FY 2021–2022 RAE 411 QUIP cumulative average of all claim type accuracy from baseline through the three months post intervention.

Table 1-9—Cumulative Average Summary of Accuracy Scores for RAEs

	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)
Baseline	69%	81%	79%	62%	85%	87%
Month 1	89%	90%	100%	100%	100%	100%
Month 2	90%	99%	97%	90%	100%	100%
Month 3	90%	97%	95%	100%	100%	100%

Note: Green shading indicates accuracy of 90 percent and higher.

HCI (Region 4) did not report any scores under 90 percent accuracy; therefore, HCI did not participate in the QUIP during FY 2021–2022.

Statewide Strengths Related to QUIPs

Based on QUIP activities conducted with the RAEs in FY 2021–2022, HSAG found the following strengths:

- The RAEs progressed from a cumulative average baseline ranging between 62 to 87 percent accuracy and increased to a cumulative average between 90 to 100 percent accuracy by the end of the project.
- Key interventions included provider education and training, electronic health record (EHR) updates, and corrective action plans (CAPs) that reinforced encounter data accuracy expectations with providers.

Statewide Opportunities for Improvement and Recommendations Related to QUIPs

HSAG found the following opportunities for improvement:

- The psychotherapy claim type still had the lowest overall data accuracy with a cumulative average of 95 percent across all encounter data types and applicable RAEs in month three.

Based on these opportunities for improvement, HSAG recommends:

- The RAEs maintain ongoing oversight of encounter data to ensure that accuracy rates remain above the 90 percent threshold; continued chart audits to monitor and improve upon specific and recurrent encounter data accuracy issues; and periodic trainings for common errors and communicating coding updates via website posting, provider newsletters, and email communications.

Mental Health Parity Audits

Table 1-10 displays the MHP Audit compliance scores for the RAEs for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 1-10—MHP Audit Summary of Scores for RAEs

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
Mental Health (MH)/Substance Use Disorder (SUD) Services					
RMHP	1	100%	Inpatient	86%	91%∨
			Outpatient	96%	
NHP	2	98%	Inpatient	100%	98%~
			Outpatient	94%	
COA Region 3	3	100%	Inpatient	100%	100%~
			Outpatient	100%	
HCI	4	99%	Inpatient	96%	94%∨
			Outpatient	88%	
COA Region 5	5	98%	Inpatient	99%	99%∧
			Outpatient	100%	
CCHA Region 6	6	84%	Inpatient	82%	86%∧
			Outpatient	91%	
CCHA Region 7	7	83%	Inpatient	78%	81%∨
			Outpatient	84%	

∨ *Indicates that the score declined as compared to the previous review year.*
∧ *Indicates that the score increased as compared to the previous review year.*
~ *Indicates that the score remained unchanged as compared to the previous review year.*

Statewide Strengths Related to MHP Audits

Based on MHP Audit activities conducted with the RAEs in FY 2021–2022, HSAG found the following strengths:

- Most RAEs demonstrated an increase or consistent compliance scores from the previous review year.
- All RAEs used nationally recognized utilization review (UR) criteria such as the Milliman Clinical Guidelines (MCG), InterQual UR criteria, and American Society of Addiction Medicine (ASAM) level of care criteria.

- All RAEs followed policies and procedures regarding interrater reliability (IRR) testing and required UM staff members to participate in IRR testing annually and earn a passing score of 80 or 90 percent.
- The Department launched new benefits for inpatient and residential SUD services on January 1, 2021, and all RAEs met the 72-hour timeliness requirement for these determinations in the first quarter.
- Within policies and procedures, all RAEs described an appropriate level of expertise required for UM staff members making denial determinations. Additionally, most RAEs demonstrated consistent documentation within the files regarding the individual who made the denial determination.
- The RAEs used a Department-approved notice of adverse benefit determination (NABD) template letter that included the required information and notified members of their right to an appeal.

Statewide Opportunities for Improvement and Recommendations Related to MHP Audits

HSAG found the following opportunities for improvement:

- Most RAEs were out of compliance for timeliness in regard to sending NABDs, despite maintaining accurate policies and procedures.
- Within each RAE's electronic documentation system, four RAEs did not consistently and adequately document offering peer-to-peer discussions with the requesting provider prior to finalizing denials when making medical necessity determinations.
- The Department determined best practices to implement regarding reason and rationale within the NABDs. However, most RAEs did not utilize all best practices within the NABDs such as name of the criteria used, brief description of the specific element of the criteria, why the RAE found the service to not be medically necessary, and the right to request a copy of the criteria used to make the determination. Additionally, to comply with Senate Bill (SB) 21-137, all health plans must demonstrate in the NABD how each dimension of the ASAM criteria was considered when making SUD denial determinations.

Based on these opportunities for improvement, HSAG recommends:

- The Department work with the RAEs to develop and implement ongoing staff training and monitoring to ensure adherence to Colorado-specific timelines when sending the NABD.
- The Department and RAEs work together to evaluate documentation protocols to ensure accuracy of documenting whether peer-to-peer reviews are offered to the requesting provider.
- Implementing ongoing monitoring by the Department to assess the RAEs' compliance with use of the Department's templates and best practices for communicating NABDs with members.

Quality of Care Concern Audit

Statewide Strengths Related to QOCC Audit

Based on QOCC Audit activities conducted with the RAEs in FY 2021–2022, HSAG found the following strengths:

- Each RAE had developed internal policies, procedures, and/or desk protocols to address potential issues with QOC and recognized the importance of having a process for handling these concerns.
- The RAEs emphasized that member safety is accorded the highest priority.

Statewide Opportunities for Improvement and Recommendations Related to QOCC Audit

HSAG found the following opportunities for improvement:

- The RAEs had various definitions categorizing QOC issues/concerns and used terms such as "grievance," "issue," "concern," and "complaint" when describing the process.
- Inconsistencies were identified throughout the following:
  - Policies/procedures/desk protocols
  - Definitions
  - Severity levels
  - Qualifications of staff members investigating
  - CAP reporting
  - Regulatory agency reporting
  - Timeline for completing investigations
  - Staff and provider training
  - Letter/form templates
  - Process for provider/facility to report
  - Tracking/trending/monitoring
  - Referral to a credentialing committee, peer review committee, and other applicable committees
  - Acknowledgment and resolution letter notifications
  - Reporting mechanisms to the Department
  - Expectations and reporting instructions for providers
  - Variations with the number of substantiated quality-of-care grievances (QOCGs)

Based on these opportunities for improvement, HSAG recommends:

- Assessing and revising policies and procedures related to QOCCs to ensure that all investigation and documentation steps are included.
- Developing and implementing staff and provider training modules and requiring staff and providers to access the training modules at regular intervals (i.e., quarterly, semiannually). Training could be an effort to bring awareness for internal staff/providers to report potential QOCCs.
- Developing and implementing tracking systems within each RAE's documentation system that ensure standardized steps taken to investigate QOCCs; ensure consistent follow-up on any corrective actions required or self-imposed by providers; and allow trending to review patterns regarding providers, diagnoses, service types, etc.
- Incorporating QOCC trending information into the quality assurance and performance improvement (QAPI) committee review for QOC improvement purposes.
- Consistently referring QOCC issues that are provider-specific to the credentialing committee for consideration during recredentialing processes.
- Developing and implementing policies and procedures to ensure that the originator/reporter of the original potential concern receives an acknowledgement and resolution letter.
- For investigations that originated following a QOCG from the member, ensuring that the member receives an acknowledgement and resolution letter consistent with the grievance process at 42 CFR §438.400 (addressing member-specific resolution such as having changed the provider, or working with the member to ensure needs are met).
- Reviewing members' experience as it relates to QOC. A member's experience can stimulate important insights into the kinds of changes that are needed to close the difference between the care that is provided and the care that should be provided.
- Developing reporting procedures and mechanisms to ensure QOCGs are reported to the State as described in the contract.
- Expanding language in the provider agreement and/or provider manual to detail that the provider is expected to inform the member about the complaint process (should speak up about observed QOCG issues and how to submit a QOCG).
- For RAEs with low numbers of documented QOCGs, incorporating additional trainings for member services and care coordination to identify QOCGs, report, document, and follow-up with the responsible internal departments.
- Streamlining the process of acknowledgment and resolution notifications with the grievance process wherever appropriate.
- Integrating member information such as race, ethnicity, and disability status into a tracking database or merging with available demographic data to monitor for issues or trends.

MCOs Providing Services Under Colorado's Accountable Care Collaborative Program

Validation of Performance Improvement Projects

Table 1-11 displays the results of the FY 2021–2022 PIP validations and summarizes how far through the four modules of the rapid-cycle PIP process each MCO progressed.

Table 1-11—FY 2021–2022 Statewide PIP Results

MCO	PIP Topic	Module Status	Validation Status
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
RMHP Prime	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2021–2022 validation cycle.*

During this validation cycle, the MCOs continued ongoing PIPs, submitting Module 3 for the rapid-cycle PIP process for validation. In Module 3, the MCO defines the plan for the intervention to be tested. During FY 2021–2022, HSAG provided technical assistance and feedback to the MCOs on the intervention testing plan, including the intervention effectiveness measure and data collection process. The MCOs continued testing interventions for the PIP until the end of the fiscal year. In FY 2022–2023, the MCOs will submit the final rapid-cycle PIP module, Module 4—PIP Conclusions, for validation and will report the final results, conclusions, and lessons learned for the PIPs.

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

Based on the PIP validation activities completed in FY 2021–2022, HSAG found the following statewide strengths:

- Both MCOs selected PIP interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Both MCOs initiated testing of PIP interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. Both MCOs addressed all Module 3 PIP validation criteria.

To support successful progression of the PIPs in the next fiscal year, HSAG recommends the following:

- The MCOs should collect complete and accurate intervention effectiveness data for each tested intervention. Each MCO should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- The MCOs should ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, the MCOs should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, the MCOs should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the MCOs should document which interventions had the greatest impact.

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 information systems (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 performance measure 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 1-12 and Table 1-13 display the Medicaid statewide weighted averages for MY 2019 through MY 2021, along with the percentile ranking for each MY 2021 rate.[1-4] HSAG compared statewide performance measure results for MY 2021 to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for MY 2020 when available for HEDIS measures. Additionally, rates for MY 2021 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2021 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-5] HSAG also

[1-4] For HEDIS measures, high-performing measure rates are those ranked at or above the national Medicaid 75th percentile without a significant decline in performance from MY 2020 or ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from MY 2020. Low-performing measure rates are those below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from MY 2020 for the MCOs (DHMP and RMHP Prime).

[1-5] For HEDIS measures, 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 MY 2020 rates may be understated or overstated.

compared statewide performance measure results for MY 2021 to the CMS Core Set Medians for federal fiscal year (FFY) 2020 when available. Additional Medicaid statewide weighted average measure rates are found in Section 4.

Table 1-12—MCO Statewide Weighted Averages for the MY 2021 High-Performing Rates

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Chlamydia Screening in Women[H]				
Ages 16 to 20 Years	68.90%	65.17%	75.11%^	≥90th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[H]				
Counseling for Nutrition—Total	9.36%	69.02%	73.46%^	50th–74th
Counseling for Physical Activity—Total	7.96%	68.02%	72.54%^	50th–74th
Maternal and Perinatal Health				
Contraceptive Care—All Women[CS]				
Long-Acting Reversible Method of Contraception (LARC)—Ages 15 to 20 Years	—	—	6.51%	ACSM
Most or Moderately Effective Method of Contraception (MMEC)—Ages 15 to 20 Years	—	—	33.58%	ACSM
Contraceptive Care—Postpartum Women[CS]				
LARC—60 Days—Ages 15 to 20 Years	—	—	19.57%	ACSM
LARC—60 Days—Ages 21 to 44 Years	—	—	16.56%	ACSM
Behavioral Health Care				
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	49.15%	55.88%	59.09%	75th–89th
Cholesterol Testing—Total	38.98%	41.18%	45.45%	75th–89th
Blood Glucose and Cholesterol Testing—Total	38.98%	35.29%	43.94%	75th–89th
Use of Services				
Plan All-Cause Readmissions[H]				
Observed to Expected (O/E) Ratio—Total	1.13	1.05	0.91	75th–89th

[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
ACSM indicates the reported rate was above the Core Set Median.

Statewide Strengths Related to Performance Measure Rates and Validation

The following HEDIS MY 2021 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 MY 2020 or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2020):

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates (i.e., ranked above the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years* and *MMEC—Ages 15 to 20 Years*
- *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*

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

Table 1-13 displays the low-performing statewide average performance measure rates for MY 2021. Rates for MY 2021 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2021 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Table 1-13—MCO Statewide Weighted Averages for the HEDIS MY 2021 Low-Performing Rates

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Cervical Cancer Screening[H]				
Cervical Cancer Screening	42.52%	40.72%	40.67%	<10th
Childhood Immunization Status[H]				
Combination 3	66.41%	67.95%	**61.94%^^**	10th–24th
Combination 7	57.40%	57.71%	**53.10%^^**	10th–24th
Immunizations for Adolescents[H]				
Combination 1 (Meningococcal, Tetanus, Diphtheria, and Pertussis [Tdap])	77.63%	75.51%	**64.92%^^**	<10th
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	50.04%	44.87%	**35.48%^^**	25th–49th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	57.22%	54.39%	<10th
Maternal and Perinatal Health				
Prenatal and Postpartum Care[H]				
Postpartum Care	50.88%	51.65%	54.89%^	<10th
Timeliness of Prenatal Care	62.81%	70.45%	68.76%	<10th
Contraceptive Care—All Women[CS]				
LARC—Ages 21 to 44 Years	—	—	4.87%	BCSM
MMEC—Ages 21 to 44 Years	—	—	20.17%	BCSM
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	0.00%	BCSM
LARC—3 Days—Ages 21 to 44 Years	—	—	0.00%	BCSM
MMEC—3 Days—Ages 15 to 20 Years	—	—	0.00%	BCSM
MMEC—3 Days—Ages 21 to 44 Years	—	—	5.77%	BCSM
MMEC—60 Days—Ages 15 to 20 Years	—	—	34.78%	BCSM
MMEC—60 Days—Ages 21 to 44 Years	—	—	40.74%	BCSM
Care of Acute and Chronic Conditions				
Asthma in Younger Adults Admission Rate*[CS]				
Ages 18 to 39 Years	—	—	6.65%	BCSM
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	59.68%	BCSM
Total (Ages 19 to 64 Years)	—	—	52.00%	BCSM
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	—	53.83%	10th–24th
Follow-Up After ED Visit for Mental Illness[H]				
30-Day Follow-Up—Ages 18 to 64 Years	—	—	36.30%	10th–24th
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication[H]				
Initiation Phase	41.59%	41.67%	31.87%	<10th

**For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
BCSM indicates the reported rate was below the Core Set Median.

The following HEDIS MY 2021 measure rates were determined to be low-performing rates (i.e., ranked below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from MY 2020) for the MCOs:

- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Ages 18 to 64 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be low-performing rates (i.e., ranked below the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 21 to 44 Years* and *MMEC—Ages 21 to 44 Years*
- *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*; and *MMEC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*, and *60 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*
- *Asthma in Younger Adults Admission Rate—Ages 18 to 39 Years*
- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)* and *Total (Ages 19 to 64 Years)*

To address these low measure rates, HSAG recommends:

- Reminding parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccination.[1-6]
- Promoting well-care visits with providers as an opportunity for providers to influence health and development, and reinforcing that well-care visits are a critical opportunity for screening and counseling.[1-7]

Assessment of Compliance With Medicaid Managed Care Regulations

Table 1-14 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 1-14—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, 2021–2022)	**86%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**93%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2018–2019, 2021–2022)	**83%**	**84%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2019–2020)	87%	86%
Standard VII—Provider 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%

1-6 The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 7, 2022.

1-7 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 7, 2022.

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2020–2021)	94%	97%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019, 2021–2022)	**93%**	**100%**

**Bold text indicates standards that HSAG reviewed during FY 2021–2022.*

Statewide Strengths Related to Compliance With Regulations

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strength:

- Both MCOs scored 100 percent compliance on three of the four standards, indicating a strong understanding of State and federal regulations.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- Both MCOs lacked the ability to monitor ad hoc printing requests were delivered to the member within five business days, critical materials lacked all components of a tagline, and some materials were well above the sixth-grade reading level. 

To address these opportunities for improvement, HSAG recommends:

- Developing a mechanism to track ad hoc printing requests, update critical materials to consistently include all components of a tagline, and enhance the review process for member materials to ensure they are easy to read.

Validation of Network Adequacy

Statewide Strengths Related to Validation of Network Adequacy

Based on NAV activities conducted with the MCOs in FY 2021–2022, HSAG found the following strengths:

- All MCOs participated in the quarterly NAV analysis. 
- The Department demonstrated significant growth in its oversight of the MCOs' networks through the development and implementation of standardized quarterly network adequacy reporting materials. 

- In the FY 2021–2022 time and distance analysis, the Colorado MCOs exhibited improvements in member access over the same activity performed in FY 2020–2021. Across MCOs, urbanicities, and practitioner network categories, there were notable improvements in the percentage of network requirements assessed for which the MCOs were meeting the Department's 100 percent standard, particularly in the PH primary care provider type. In rural and frontier counties, Medicaid MCOs displayed increased access, respectively for the PH primary care provider type.[1-8]
- Within the PH specialist provider type, the Medicaid MCOs exhibited marked increases in the percentage of network requirements with 100 percent of members meeting the standards in both rural and frontier counties, and with 82.5 percent of rural and 97.5 percent of frontier PH specialist requirements now meeting the standards.

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

HSAG found the following opportunities for improvement:

- 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. For an MCO to meet the minimum network requirements outlined in its contract with the Department, 100 percent of the MCO's enrolled members must have addresses within the minimum network requirements (i.e., a 100 percent access level).
- An MCO's failure to meet a minimum network requirement does not necessarily reflect a network concern, and the MCO may employ alternate methods for ensuring members' access to care (e.g., the use of telehealth).

To address these opportunities for improvement, HSAG recommends:

- The Department consider continuing the development and implementation of a formal network exception policy and request templates to address network adequacy concerns in circumstances in which the MCOs are persistently unable to meet applicable Colorado NAV time and distance standards.
- The Department consider the extent to which the MCOs offer alternate service delivery mechanisms (e.g., telehealth) to ensure members' access to care in instances where the MCO networks are not meeting the geographic access standards as defined. The Department could consider incorporating such alternative delivery mechanisms into how the access standards are evaluated.

[1-8] NAV results for DHMP's minimum BH network requirements are included in the RAEs' aggregated BH results because DHMP is contracted to provide behavioral healthcare services to its members, similar to the RAEs' contractual requirements.

- The Department consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population needs. Although current network standards developed by the Department were designed to assess the number of specific provider types located within given driving times and distances from members, the adequacy of the networks to address specific population needs may be more comprehensively assessed by including and cross-referencing encounter data to assess actual utilization patterns.

Encounter Data Validation—MCO 412 EDV Over-Read

Table 1-15 presents the MCOs' self-reported encounter data service coding accuracy results by service category and validated data element.

Table 1-15—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	95.6%	86.9%	77.7%	94.7%	88.7%
Through Date	96.1%	NA	NA	NA	96.1%
Primary Diagnosis Code	92.7%	80.6%	66.0%	88.8%	82.0%
Primary Surgical Procedure Code	96.6%	NA	NA	NA	96.6%
Discharge Status	93.2%	NA	NA	NA	93.2%
Procedure Code	NA	82.5%	66.5%	83.0%	77.3%
Procedure Code Modifier	NA	85.9%	77.2%	91.3%	84.8%
Units	NA	85.0%	76.2%	94.2%	85.1%

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

*** Federally Qualified Health Center*

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 1-16 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 1-16—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	95.0%	240	96.7%
Outpatient	40	92.5%	200	97.5%

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
Professional	40	100.0%	200	100.0%
FQHC	40	90.0%	200	96.0%
Total	**160**	**94.4%**	**840**	**97.5%**

** HSAG sampled 20 cases per MCO from each service category (i.e., 40 cases total per service category).*

Statewide Strengths Related to MCO 412 EDV Over-Read

Based on EDV activities conducted with the MCOs in FY 2021–2022, HSAG found the following strengths:

- Results from HSAG's 412 EDV over-read suggest a high level of confidence that RMHP Prime's and DHMP's 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 EDV Over-Read

HSAG found the following opportunities for improvement:

- 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.

Based on these opportunities for improvement, 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' PH encounter data submissions, and verifying that the MCO is routinely monitoring encounter data quality beyond the annual 412 EDV.

CAHPS Surveys

Table 1-17 shows the adult Medicaid statewide CAHPS results for FY 2021–2022.[1-9]

Table 1-17—FY 2021–2022 Adult Medicaid Statewide CAHPS Results for MCOs

Measure	FY 2021–2022 DHMP Score	FY 2021–2022 RMHP Prime Score
Rating of Health Plan	58.6%	58.5%
Rating of All Health Care	52.8%	49.3% ↓
Rating of Personal Doctor	68.9% ▼	61.2% ↓
Rating of Specialist Seen Most Often	70.6%	71.1%+
Getting Needed Care	71.7% ↓ ▼	83.6%
Getting Care Quickly	71.3% ↓	80.2%
How Well Doctors Communicate	92.1%	87.4% ↓
Customer Service	87.9%	88.7%+

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

Table 1-18 shows the child Medicaid statewide CAHPS results for FY 2021–2022.[1-10,1-11]

Table 1-18—FY 2021–2022 Child Medicaid Statewide CAHPS Results for MCOs

Measure	FY 2021–2022 DHMP Score	FY 2021–2022 RMHP Prime Score
Rating of Health Plan	72.3%	68.7%
Rating of All Health Care	70.7%+	63.2% ↓ ▼
Rating of Personal Doctor	82.3%	69.4% ↓
Rating of Specialist Seen Most Often	87.5%+	79.6%+
Getting Needed Care	80.2%+	85.4%

[1-9] 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.

[1-10] Ibid.

[1-11] 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.

Measure	FY 2021–2022 DHMP Score	FY 2021–2022 RMHP Prime Score
Getting Care Quickly	82.1%+	87.5%
How Well Doctors Communicate	93.7%+	96.8% ↑
Customer Service	89.6%+	89.1%+

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

Statewide Strengths Related to CAHPS Surveys

Adult

For the adult population, the following measure's FY 2021–2022 score for DHMP was higher, although not statistically significantly higher, than the 2021 NCQA national average:

- *Rating of Specialist Seen Most Often*

For the adult population, the following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly higher, than the FY 2020–2021 scores:

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

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were higher, although not statistically significantly higher, than the 2021 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were higher, although not statistically significantly higher, than the FY 2020–2021 scores:

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

Child

For the child population, the following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly higher, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Customer Service*
- *Coordination of Care*

For the child population, the following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly higher, than the FY 2020–2021 scores:

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

For the child population, the following measure's FY 2021–2022 score for RMHP Prime was statistically significantly higher than the 2021 NCQA national average:

- *How Well Doctors Communicate*

For the child population, the following measure's FY 2021–2022 score for RMHP Prime was higher, although not statistically significantly higher, than the FY 2020–2021 score:

- *Rating of Specialist Seen Most Often*

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

Adult

For the adult population, the following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the 2021 NCQA national averages:

- *Getting Needed Care*
- *Getting Care Quickly*

For the adult population, the following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the FY 2020–2021 scores:

- *Rating of Personal Doctor*
- *Getting Needed Care*

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were lower, although not statistically significantly lower, than the FY 2020–2021 scores:

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

To address these low CAHPS scores, HSAG recommends:

- The Department collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of quality of care (QOC).
- DHMP and RMHP Prime conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received, as applicable, to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- DHMP and RMHP Prime explore provider processes and develop initiatives designed to improve performance including enhancing provider informational materials and exploring providers' ability to communicate effectively with members.
- RMHP Prime explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.

Child

For the child population, the following measures' FY 2021–2022 scores for DHMP were lower, although not statistically significantly lower, than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

For the child population, the following measures' FY 2021–2022 scores for DHMP were lower, although not statistically significantly lower, than the FY 2020–2021 scores:

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

For the child population, the following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

For the child population, the following measure's FY 2021–2022 score for RMHP Prime was statistically significantly lower than the FY 2020–2021 score:

- *Rating of All Health Care*

To address these low CAHPS scores, HSAG recommends:

- The Department collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of QOC.
- DHMP and RMHP Prime conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received, as applicable, to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.

- DHMP explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.
- RMHP Prime:
  - Explore provider processes and develop initiatives designed to improve performance including enhancing provider informational materials and exploring providers' ability to communicate effectively with members.
  - Explore reasons the MCO's FY 2021–2022 score for *How Well Doctors Communicate* was statistically significantly higher than the 2021 NCQA national average and determine if any best practices can be shared with DHMP and actions duplicated to improve the score.

For additional information about MCO CAHPS results for FY 2021–2022, refer to the Medicaid aggregate CAHPS report found on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

Quality Improvement Plans

Table 1-19 presents the FY 2021–2022 MCO 412 QUIP cumulative average of all claim type accuracy from baseline through the three months post intervention.

Table 1-19—Cumulative Average Summary of Accuracy Scores for MCOs

	DHMP	RMHP Prime
Baseline	82%	78%
Month 1	70%	97%
Month 2	76%	99%
Month 3	79%	99%

Statewide Strengths Related to QUIPs

Based on QUIP activities conducted with the MCOs in FY 2021–2022, HSAG found the following strengths:

- Both MCOs showed that the interventions resulted in improved accuracy scores for encounter data types, notably RMHP Prime, which progressed from an accumulative average baseline of 78 to 99 percent accuracy by the end of Phase 3.
- Both MCOs incorporated a training component into the QUIP interventions as part of their strategy to inform providers about expectations on documentation requirements and streamline quality improvement (QI) interventions to improve overall encounter data accuracy.

Statewide Opportunities for Improvement and Recommendations Related to QUIPs

HSAG found the following opportunities for improvement:

- Both MCOs identified inaccurate or incomplete information in the medical record as barriers and used education to support provider improvements in encounter data type accuracy rates.
- Both MCOs reported difficulties and irregularities in provider participation and in receiving medical records, which resulted in varied improvements across the three months of implementation.
- By the end of the intervention period, although it reported performance improvement with a few encounter data types, DHMP's overall average accuracy rate declined from 82 to 79 percent.

Based on these opportunities for improvement, HSAG recommends:

- Both MCOs maintain ongoing auditing and oversight of providers' claims submissions that continue to result in encounter data accuracy below the 90 percent threshold, and continue to develop and enhance a training and feedback loop with providers to address ongoing accuracy issues.

Mental Health Parity Audits

Table 1-20 displays the MHP Audit compliance scores for the MCOs for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 1-20—MHP Audit Summary of Scores for MCOs

MCO	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD and Medical/Surgical (M/S) Services				
DHMP	100%	Inpatient	99%	97%∨
		Outpatient	96%	
RMHP Prime	100%	Inpatient	87%	89%∨
		Outpatient	91%	

∨ *Indicates that the score declined as compared to the previous review year.*

Statewide Strengths Related to MHP Audits

Based on MCO MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths:

- The MCOs used nationally recognized UR criteria such as the MCG and InterQual UR criteria for MH determinations and ASAM level of care criteria for all SUD determinations.
- DHMP and RMHP Prime followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually and earn a passing score of 80 or 90 percent.
- The Department launched new benefits for inpatient and residential SUD services on January 1, 2021, and the MCOs met the 72-hour timeliness requirement for these determinations in the first quarter.
- Within policies and procedures, DHMP and RMHP Prime described an appropriate level of expertise required for UM staff members making denial determinations.
- DHMP and RMHP Prime used a Department-approved NABD template letter that included the required information and notified members of their right to an appeal.

Statewide Opportunities for Improvement and Recommendations Related to MHP Audits

The MCOs did not have any statewide opportunities for improvement; therefore, there are no statewide recommendations from HSAG.

Quality of Care Concern Audit

Statewide Strengths Related to QOCC Audit

Based on QOCC Audit activities conducted with the MCOs in FY 2021–2022, HSAG found the following strengths:

- Each MCO had developed internal policies, procedures, and/or desk protocols to address potential issues with QOC and recognized the importance of having a process for handling these concerns.
- The MCOs emphasized that member safety is accorded the highest priority.

Statewide Opportunities for Improvement and Recommendations Related to QOCC Audit

HSAG found the following opportunities for improvement:

- The MCOs had various definitions categorizing QOC issues/concerns and used terms such as "grievance," "issue," "concern," and "complaint" when describing the process.
- Inconsistencies were identified throughout the following:
  - Policies/procedures/desk protocols
  - Definitions
  - Severity levels
  - Qualifications of staff members investigating
  - CAP reporting
  - Regulatory agency reporting
  - Timeline for completing investigations
  - Staff and provider training
  - Letter/form templates
  - Process for provider/facility to report
  - Tracking/trending/monitoring
  - Referral to a credentialing committee, peer review committee, and other applicable committees
  - Acknowledgment and resolution letter notifications
  - Reporting mechanisms to the Department
  - Expectations and reporting instructions for providers
  - Variations with the number of substantiated QOCGs

Based on these opportunities for improvement, HSAG recommends:

- Assessing and revising policies and procedures related to QOCCs to ensure that all investigation and documentation steps are included.
- Developing and implementing staff and provider training modules and requiring staff and providers to access the training modules at regular intervals (i.e., quarterly, semiannually). Training could be an effort to bring awareness for internal staff/providers to report potential QOCCs.
- Developing and implementing tracking systems within each MCO's documentation system that ensure standardized steps taken to investigate QOCCs; ensure consistent follow-up on any corrective actions required or self-imposed by providers; and allow trending to review patterns regarding providers, diagnoses, service types, etc.
- Incorporating QOCC trending information into the QAPI committee review for QOC improvement purposes.
- Consistently referring QOCC issues that are provider-specific to the credentialing committee for consideration during recredentialing processes.
- Developing and implementing policies and procedures to ensure that the originator/reporter of the original potential concern receives an acknowledgement and resolution letter.
- For investigations that originated following a QOCG from the member, ensuring that the member receives an acknowledgement and resolution letter consistent with the grievance process at 42 CFR §438.400 (addressing member-specific resolution such as having changed the provider, or working with the member to ensure needs are met).
- Reviewing members' experience as it relates to QOC. A member's experience can stimulate important insights into the kinds of changes that are needed to close the difference between the care that is provided and the care that should be provided.
- Developing reporting procedures and mechanisms to ensure QOCGs are reported to the State as described in the contract.
- Expanding language in the provider agreement and/or provider manual to detail that the provider is expected to inform the member about the complaint process (should speak up about observed QOCG issues and how to submit a QOCG).
- For MCOs with low numbers of documented QOCGs, incorporating additional trainings for member services and care coordination to identify QOCGs, report, document, and follow-up with the responsible internal departments.
- Streamlining the process of acknowledgment and resolution notifications with the grievance process wherever appropriate.
- Integrating member information such as race, ethnicity, and disability status into a tracking database or merging with available demographic data to monitor for issues or trends.
- For MCOs that delegate QOCC activities, consider developing proactive monitoring processes for delegated activities (i.e., regular reporting and trending). Additionally, the MCO could consider reviewing and updating applicable policies to clearly articulate the process for delegating/referring BH QOCCs to the delegated entity.

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 healthcare system for managing costs, utilization, and quality. This model was developed in an effort to create a person-centered, coordinated, community-based healthcare system that focuses on improving the QOC 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.

Colorado's Six Pillars

Figure 1-3 displays the six pillars the Department has defined to help focus its work on the Department's mission: *Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* The pillars are reflected in the quality strategy goals selected by the Department.

Figure 1-3—Colorado's Six Pillars

Pillar: Member Health

- Implement Health Equity Plan
- Transform behavioral health
- Implement QI initiatives
- Advance hospital transformation program

The Department developed a new FY 2022–2023 Health Equity Plan (HEP) that applies a health equity lens across all programs and initiatives. The HEP aligns with the Governor's Executive Order 175, SB 21-18 which focus on addressing health disparities. The Department includes the HEP requirements and initiatives in its RAE and MCE contracts as of July 1, 2022. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the Medicaid program's efforts on vaccinations (COVID-19), maternity and perinatal health, BH, and prevention. These efforts include ongoing work to close COVID-19 vaccination disparity gaps, maternity research and reporting, BH investments transformation, increasing access to prevention, and expansion of quality care. These efforts may lead to performance measure rate improvement as the work progresses.

The Department implemented targeted and intentional conversations to engage stakeholders in meaningful dialogue, feedback, and grassroots strategy. These conversations occurred in town halls, listening sessions, public meetings, and on the Department's Health Equity website. The Department encouraged conversations and feedback from members with lived experience, RAEs, MCEs, and community stakeholders from all intersectional identities. These targeted and intentional conversations may result in increases in member satisfaction and member experience survey results.

The Department developed robust dashboards that stratified data to provide the current or most updated disparity data and embedded a health equity lens in metric deliverables and analytics. The Department stratified quality data, CMS Core Set measure data, and Department goals and measurements by race/ethnicity, gender, language, geography, disability, and other available identifiers. The dashboard provides additional data that can be used by the RAEs and the Colorado Child Health Plan *Plus* (CHP+) plans to target interventions to improve performance measure rates.

The Department's BH transformation includes increasing dollars in BH care; increasing the number of active BH providers to over 10,000, which is an increase of over 1,100 during the last year, and growing the safety net, with federal supports. The Department used federal stimulus dollars for community grant funding, mobile crisis and secure transport, increasing high-intensity outpatient services, preventing hospitalization, giving people additional wraparound services, step-down services for youth with complex needs, culturally competent training for providers, and integrated care grants. NAV should be positively impacted by these efforts.

The Department's QI priorities included enhancing the ability to measure CMS adult and child Core Set measures; enhancing the transparency around quality metric performance; aligning RAE, CHP+, and other incentive program metrics with the CMS Core Measures; and including more detailed member experience data (CAHPS) such as member experience in culturally sensitive care.

Pillar: Care Access

- Expand and support health care workforce
- Increase number and percentage of providers seeing members
- Transform residential, community-based care
- Redesign case management

The Department worked with the RAEs and MCOs to expand the network of care. The Department expanded access to care by growing the provider network by 28 percent over the last few years. The Department has approximately 95,000 providers enrolled in the provider network, of which approximately 11,700 were added during the last year. The Department has approximately 10,000 active BH providers, of which 1,100 were added in the last year. To further increase access to care, two-thirds of telemedicine visits were for BH services. NAV should be positively impacted by these efforts. It is also anticipated that member experience survey results may reflect improvement in members' experience in access to care.

The Department continued to craft programs and services to support people with disabilities to live in their homes and their communities. To accomplish this, the Department implemented widespread rate increases, identified as a national leader in electronic visit verification processes, and provided much needed support for the direct care workers. Figure 1-4 contains the Department's direct care workforce goals:

Figure 1-4—Direct Care Workforce Goals

The Department established a case management redesign framework. The policy framework included the categories of:

- New structure.
- Knowledge.
- Conflict free.
- Accountability.

The assessment and support plan framework included a new:

- Assessment tool.
- Person-centered budget algorithm.
- Information technology system.

Colorado is also investing significant dollars to support rural hospitals. Other rural investments include expanding broadband to support telemedicine policies. The Department has invested heavily in a rural support fund for technology, telemed, analytics, staff, BH, and more. The Department's investment includes increasing health information technology/health information exchange connectivity with the Colorado Office of eHealth Innovation (OeHI). An investment has also been made to connect the remaining 60 independent rural providers with OeHI. These investments may result in improved network adequacy, member access to care performance measures, and member experience.

Pillar: Operational Excellence and Customer Service

- Enable coverage continuity
- Make eligibility and enrollment easy
- Improve Medicaid enterprise solutions
- Ensure service quality network-wide

The Department expanded efforts to connect children and families to coverage. The Department's work was supported by the historic passing of Health Benefits for Colorado Children and Pregnant People (HB22-1289), which waives CHP+ enrollment and renewal fees, creates a lactation benefit, and creates Medicaid and CHP+ look-alike programs for children and pregnant people without documentation.

The Department expanded coverage for family planning and related services for more people. Colorado also increased coverage after pregnancy/birth from 90 days to 12 months. These coverage expansions enabled coverage continuity for members.

The Department handled an approximate 30 percent membership growth and completed 137 Medicaid enterprise system updates without major operational issues. The Medicaid enterprise system updates focused on solutions, innovation, system integration, and interoperability. Examples of this work include making BH claims submission and payment easier and ensuring the Department's system updates and RAE system migrations are completed without disruptions. The Medicaid enterprise system updates improving claims submission processes should result in improved EDV results.

The Department also focuses on improving member experience with the Medicaid and CHP+ programs. On average, the holds time for calls into the Member Contact Center during FY 2022 was 35 seconds. The Member Contact Center representatives actively listen to members and escalate complaints when needed. The Department holds all partners to these same high member experience standards.

Pillar: Health First Colorado Value

- Expand value-based payments and insights
- Implement eConsult and telehealth strategy
- Develop accountable care collaborative 3.0 strategy
- Produce cost and quality indicators

The Department continued development of eConsult to support PCPs and to improve the referral process. eConsult allows asynchronous electronic clinical communications between primary care medical providers (PCMPs) and specialists. eConsult will be used by the Department to enable referrals to higher performing docs, reducing disparities and improving quality. These efforts are expected to expand care in the PCP office by improving access while reducing the specialist "no-shows." The Department anticipates supporting eConsult through value-based payments that reward results. The Department anticipates the eConsult platform to go live in the summer or fall of 2023.

Colorado continued to shift payments from volume to value. The Health First Colorado Value Based Care initiative includes payment based on better care for members, reducing healthcare disparities, and care affordability. The Health First Colorado Value-Base Care initiative accelerated the percentage of payments that were tied to quality and value including primary care alternative payments and maternity bundled payments. The Department's primary care alternative payment process allows PCPs to choose to receive some or all of their revenue as a per member per month (PMPM) payment which results in stable revenue, increased investment in care improvement, and the ability of PCPs to share in savings from improved chronic care management by providing high quality person-centered care. In addition, the Department's maternity bundled payments covers all prenatal care. This value-based care option rewards providers for improving outcomes and closing health disparities.

Pillar: Affordability Leadership

- Reduce commercial pharmacy costs
- Promote transparent hospital prices
- Advance community and rural investment
- Propel and align value-based payments

The Department also focused efforts on safety net accountability. This work included advancing value-based payments for safety net providers. This will allow more flexible funds, based on patient outcomes, beginning in July 2023. The Department is using universal contracts to reduce administrative burden for providers in the public health system, which contains clear and aligned roles for all parties and is connected to value-based payments.

Colorado implemented a new hospital price transparency law. The Department also created a new hospital price dataset and tools. Although the Medicaid overall prescription trend is flat, the State made progress on opportunities to reduce prescription drug costs including implementing Medicaid value-based contracts that hold drug manufacturers accountable for clinical outcomes while rewarding

prescribers for being part of the affordability solution. The MCE contracts include provisions to ensure that 100 percent of prescription rebates are used to lower costs for employers and consumers. Colorado also implemented a Prescription Drug Affordability Board, which has the authority to review prescription drugs and evaluate if certain drugs are unaffordable to Coloradans, establish upper payment limits for drugs, and make policy recommendations to the Colorado General Assembly.

Pillar: Employee Satisfaction

- Quickly and carefully fill open positions
- Accelerate equity, diversity, inclusion, accessibility
- Address manager workload
- Foster career growth and flexibility

Goals, Objectives, and Statewide Recommendations

The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve the quality of, timeliness of, and access to care based on the Department's strategic QI goals and associated objectives. Based on EQR findings for FY 2021–2022, HSAG recommends the following to target and improve statewide performance and achieve the Department's quality strategy selected goals and objectives.

Goal 1: Decreasing health care cost and increasing affordability for individuals, families, employers and government

HSAG Recommendations

- 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.
- Consider using the results of the Department's RAE 411 and MCO 412 EDV studies to evaluate QI opportunities and PIPs.
- Consider enhancing and expanding incentive measure programs for BH and MCO PH to decrease costs and increase care affordability.

Goal 2: Enhancing delivery system innovation

- Increase and monitor members' access to care and provider network adequacy.
- Increase and strengthen partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care.
- Protect and improve the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.

- Implement pay-for-performance (P4P) with providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients.

HSAG Recommendations

- 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. Continue to 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. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.
- Consider working with RAEs and MCOs to share performance measure best practices, identify interdependencies across measures, and develop a regularly scheduled process to monitor interventions and review progress toward meeting Department-established goals.
- Enhance RAE and provider P4P programs through PMPM enhanced payment for meeting key performances indicator goals. The Department should consider low-performing HEDIS and Core Set performance measures as a potential focus in its P4P programs.
- Encourage the MCOs and RAEs to invest in neighborhood health through community-based partnerships by supporting proven interventions that address social determinants of health (SDOH) and healthy lifestyles that improve population health.
- To address identified access to care concerns, the Department could consider continuing 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. In addition to continuing efforts to expand the contracted provider network, the Department is encouraged to work with the RAEs and MCOs to develop a plan to address network gaps, particularly in rural and frontier counties, that considers expanded transportation to needed providers, single case agreements for needed care, and telehealth services.

Goal 3: Improving Patient Safety

- Ensure members are connected to the right care, at the right time, every time
- Promote effective prevention and treatment of chronic disease

HSAG Recommendations

- Continue health plan monitoring by conducting routine health plan-specific performance review meetings that focus health plan efforts to improve performance on targeted objectives in selected performance metrics. Focusing on performance metrics included in HEDIS or the CMS Core Set measures, which are based on evidence-based and recommended care guidelines, will strengthen the health plan's opportunities to promote effective prevention and treatment of chronic disease.
- Increase monitoring of health plan care coordination staffing, member engagement, outreach, member and provider follow-up, and delegation oversight. Work with the RAEs and MCOs to

expand monitoring of the clarity and effectiveness of care coordination member materials, including those focused on preventive care and treatment of chronic disease.

- Consider rewarding or recognizing creative care coordination programs that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions; assess and refer members to appropriate community partners to address SDOH; and connect members to the right care, at the right time, every time.

Goal 4: Improving health outcomes, member experience, and patient safety through clinical analytics, evidence-based practices, and adoption

HSAG Recommendations

- To improve members' experience with the health plans, the Department should consider collaborating with the health plans to encourage consistency in the grievance and appeals processes including use of operational definitions, appropriate identification of QOCCs, use of investigative QOC resolution steps, more consistent compliance with member acknowledgement and meeting notice time frame requirements, system tracking and trending of grievances and appeals, creating standard definitions of grievance and appeal categories, and inclusion of both grievance and appeal resolution results in provider profiles for credentialing purposes. In addition, the Department could consider encouraging the health plans to include use of reported member experiences with the grievance and appeal systems in developing QI initiatives.
- In addition to the use and adoption of evidence-based practices and guidelines, the Department should consider encouraging health plans to assess UR turnaround times and communications to members related to UR processes. Members' perceptions of authorization processes and timeliness may impact member experience survey measures.
- 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.

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 mandatory and optional EQR-related activities that HSAG conducted with the Medicaid health plans throughout FY 2021–2022.

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 2021–20222 with a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQR activities in FY 2021–2022. 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 of, 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 of, 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 2020–2021 Recommendations provides, by EQR activity, an assessment of the extent to which each health plan was able to follow up on and complete any recommendations or corrective actions required as a result of the FY 2020–2021 EQR-related activities.

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

Definitions

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

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] 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.[1]

Access

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

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."[3] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] Ibid.
[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

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 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.

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), 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 mode 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 2021–2022, 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 June 30, 2022, RMHP will partner with St. Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE members attributed to either SMFM or MFHC ages 12 years and older, from 0.63% to 20.00%.	Claims and enrollment data
	By June 30, 2022, RMHP will partner with SMFM and MFHC 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 ages 12 years and older, from 28.57% to 46.89%.	Claims and enrollment data
Region 2—NHP	By June 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%.	EHR data on enrollment and encounters
	By June 30, 2022, use key driver diagram interventions to increase the percentage of BH 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 June 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 June 30, 2022, use key driver diagram interventions to increase the percentage of BH 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

RAE	SMART Aims	Data Sources
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
	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 among unduplicated CCHA members 12 years or older from 49.27% to 53.01%.	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 BH service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years or older from 75.00% to 93.75%.	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 62.08% to 63.53%.	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 BH 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 72.10% to 75.74%.	Encounter and FFS claims data
MCO	**SMART Aims**	**Data Sources**
DHMP	By June 30, 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, from 65.86% to 68.86%.	Enrollment data, claims data, and electronic medical record (EMR) data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics from 47.89% to 58.89%.	Enrollment data, claims data, and EMR data

MCO	SMART Aims	Data Sources
RMHP Prime	By June 30, 2022, Rocky Mountain Health Plans (RMHP) will partner with MFHC and SMFM to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime members aged 12 and older from 0.55% to 20.0%.	Claims and enrollment data
	By June 30, 2022, Rocky Mountain Health Plans (RMHP) will partner with MFHC and SMFM 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 BH services within 30 days from 37.50% 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.[2-1]

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 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.

[2-1] 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 11, 2022.

- ***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 of, timeliness of, and access to services provided by the Medicaid health plans, HSAG assigned each project 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*	✓	✓	✓
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 reported by the RAE.
- Determine the extent to which the specific performance measures reported 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 MY 2021 (i.e., July 1, 2020, through June 30, 2021) performance measures be validated during FY 2021–2022 based on the specifications outlined in the *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2020–2021*, which was written collaboratively by the RAEs and the Department.[2-2] 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 2020–2021 calculation of measures, 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,[2-3] 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

[2-2] Colorado Department of Health Care Policy and Financing. *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2020–2021.*

[2-3] 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 11, 2022.

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 incentive performance measure rates. 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 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 2021–2022 PMV activities:

- **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 MY 2021 performance measure rates were compared to the Department's established performance targets and are denoted in Table 2-3.

Table 2-3—MY 2021 Performance Targets

Performance Measure	Performance Target*
Engagement in Outpatient SUD Treatment	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	48.22%
Follow-Up After a Positive Depression Screen	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	30.56%

**Performance targets are specified in the Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2020–2021.*

To draw conclusions about the quality of, 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 SUD Treatment	✓	✓	✓
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	✓	✓	✓
Follow-Up Within 7 Days of an ED Visit for 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 (LOB). 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 2021 (due to COVID-19) regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[2-4]

- 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 and non-HEDIS measure 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.

[2-4] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS and non-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 and non-HEDIS measure data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS and non-HEDIS MY 2021 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) and CMS Core Set rate reporting template 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.

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for MY 2021 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 whether 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 and a custom rate reporting template for those CMS Core Set measures that are non-HEDIS measures were reviewed to determine trending patterns and rate reasonability. Please note that all rates HSAG included in this report were those rates according to the CMS Adult and Child Core Set specifications. Age stratifications for the Core Set measures may differ from HEDIS age stratifications.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the audited results submitted to the Department by the two MCOs for Medicaid, which included each MCO's FAR, IDSS, and custom reporting templates. HSAG used the final audit results and the FAR as the primary data sources to tabulate overall 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' performance 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 addition to these comparisons, all non-HEDIS measures, where applicable, were evaluated against state-reported medians for benchmarking. In the performance measure results tables, HEDIS rates shaded green with one caret (^) indicate statistically significant improvement in performance from MY 2020 to MY 2021. HEDIS rates shaded red with two carets (^^) indicate statistically significant declines in performance from MY 2020 to MY 2021. 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 2021 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020, when available. Additionally, results for non-HEDIS MY 2021 measures were compared to CMS State Core Set Medians for FFY 2020, 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 submission. This symbol may also indicate that a percentile ranking was not determined, either because the MY 2021 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 2020.

  - Ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2020.

- 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 2020.

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 MY 2019, MY 2020, and MY 2021 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 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 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—Core Set Measures That Can Be Reported Using the Hybrid Methodology

HEDIS Measures
Primary Care Access and Preventive Care
Cervical Cancer Screening
Childhood Immunization Status
Colorectal Cancer Screening
Immunizations for Adolescents
Developmental Screening in the First Three Years of Life
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Maternal and Perinatal Health
Prenatal and Postpartum Care
Care of Acute and Chronic Conditions
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

HEDIS Measures
Behavioral Health Care
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%)

To draw conclusions about the quality of, 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
Primary Care Access and Preventive Care			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Chlamydia Screening in Women	✓		
Colorectal Cancer Screening	✓	✓	✓
Immunizations for Adolescents	✓		
Screening for Depression and Follow-Up Plan	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Maternal and Perinatal Health			
Contraceptive Care—All Women	✓	✓	✓
Contraceptive Care—Postpartum Women	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Care of Acute and Chronic Conditions			
Asthma Medication Ratio	✓		
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓		
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	✓		
Controlling High Blood Pressure	✓	✓	
Human Immunodeficiency Virus (HIV) Viral Load Suppression	✓		
Plan All-Cause Readmissions	✓		
PQI 01: Diabetes Short-Term Complications Admission Rate	✓		

Performance Measure	Quality	Timeliness	Access
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	✓		
PQI 08: Heart Failure Admission Rate	✓		
PQI 15: Asthma in Younger Adults Admission Rate	✓		
Behavioral Health Care			
Antidepressant Medication Management	✓		
Concurrent Use of Opioids and Benzodiazepines	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%)	✓		
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence	✓	✓	✓
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Opioids at High Dosage in Persons Without Cancer	✓		
Use of Pharmacotherapy for Opioid Use Disorder	✓	✓	✓
Use of Services			
Ambulatory Care: ED Visits	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).

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, MY 2019, MY 2020, and MY 2021 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for MY 2019, MY 2020, and MY 2021, 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.

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	Year Reviewed
Standard I—Coverage and Authorization of Services	438.114 438.210	2019–2020
Standard II—Adequate Capacity and Availability of Services	438.206 438.207	2019–2020
Standard III—Coordination and Continuity of Care	438.208	2021–2022
Standard IV—Member Rights, Protections, and Confidentiality	438.100 438.224	2021–2022
Standard V—Member Information Requirements	438.10	2021–2022
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416	2019–2020

Standard Number and Title	Regulations Included	Year Reviewed
	438.420 438.424	
Standard VII—Provider Selection and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610	2020–2021
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines	2020–2021
Standard IX—Subcontractual Relationships and Delegation	438.230	2020–2021
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	438.330 438.236 438.240 438.242	2020–2021
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280	2021–2022
Standard XII—Enrollment and Disenrollment	438.3(d) 438.56	Scheduled for FY 2022–2023

For the FY 2021–2022 compliance review process, the standards reviewed were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard.

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 compliance 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.[2-5] 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 web-based conferencing to conduct the FY 2021–2022 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 desk request forms, compliance monitoring tools, report templates, and agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval.

[2-5] 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 11, 2022.

For this step,	HSAG completed the following activities:
	• HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's 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 interview 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. 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 HSAG review team reviewed all documentation submitted prior to the interview 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 interview 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 also requested and reviewed additional documents as needed based on interview responses. • At the close of the interview 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 contracts, agreements, manuals, and directories
- 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
- Interviews with key health plan staff members conducted on-site or virtually

How Data Were Aggregated and Analyzed

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, 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 (where available) 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

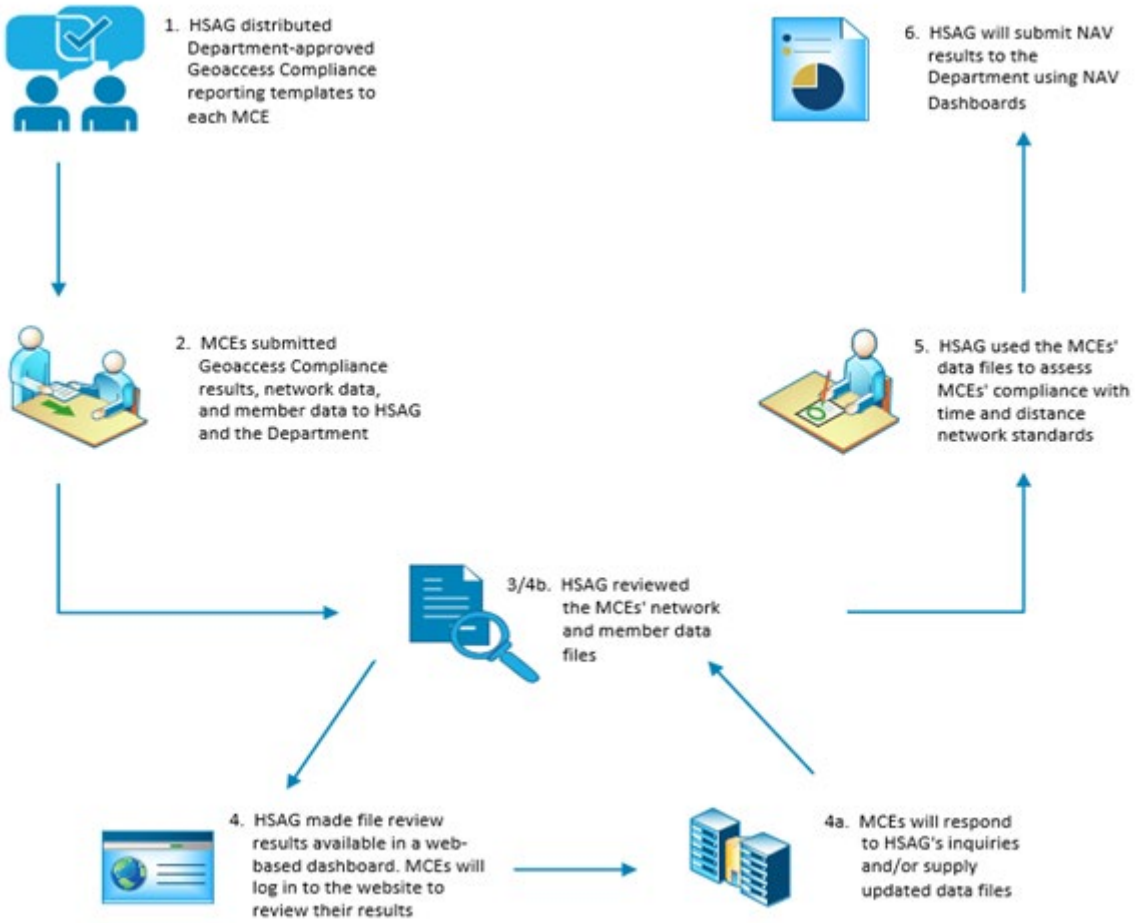
Compliance Review Standard	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Member Rights, Protections, and Confidentiality	✓		✓
Standard V—Member Information Requirements			✓
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	✓	✓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

Validation of Network Adequacy

Objectives

The purpose of the FY 2021–2022 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 2021–2022 NAV 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.[2-6,2-7] Table 2-10 presents the network domains applicable to MCOs and RAEs; within each domain, network categories included in the FY 2021–2022 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 15, 2021, HSAG reminded each health plan of the January 31, 2022, deadline to submit the FY 2021–2022 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

2-6 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 11, 2022.

2-7 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.

support consistent network definitions across the health plans and over time, HSAG supplied the health plans with the Department-approved September 2021 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 member files from the Department using a detailed member data requirements document for members actively enrolled with a health plan as of December 31, 2021. During the FY 2021–2022, 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).

The Department used the FY 2021–2022 NAV to build upon prior years' NAV activities, expanding the visual display of NAV results to include trended results from previous quarters, and a results brief download designed to replace the previously developed MCE-specific results briefs. HSAG also developed an Enhanced File Review dashboard to streamline the review of the MCEs' data submission files and presentation of the results to indicate areas where the MCEs should resubmit or clarify the data. HSAG and the Department further explored the impact of using alternate time and distance standards as compared to the current 100 percent standard to better understand how the current standards may contribute to the results obtained in recent years. Finally, HSAG drafted an exception request process requirements document and an exception request template form for the consideration of the Department. The document outlines a process and is accompanied by a spreadsheet template that the MCEs may use to submit exception requests to the Department. The draft exception request may serve as a starting point for future decisions should the Department choose to move forward with implementing a formal exception request process.

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. Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid and CHP+ member and network files from the Department for members enrolled with an MCE and practitioners, practices, and entities enrolled in *interChange*.

During the FY 2021–2022 NAV, HSAG used the Department's member and network data within the Network Adequacy Data Initial Validation process to assess the completeness and accuracy of the MCEs' member data.

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 2021–2022 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 2021.3 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.[2-8] 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.

[2-8] 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 21, 2022.

How Conclusions Were Drawn

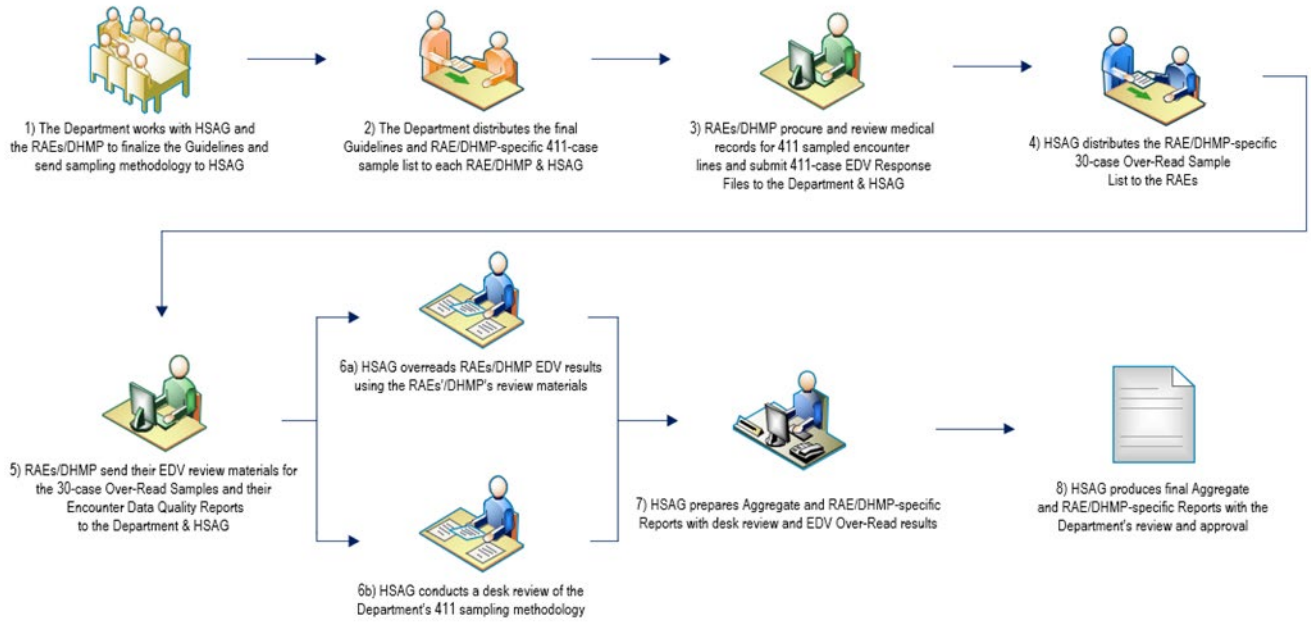
HSAG used the RAEs' and Medicaid MCOs' quarterly geoaccess compliance reports and provider data, and the Department's member data to perform the geoaccess analysis specific to each health plan. HSAG reviewed the results of the compliance mismatch analysis to identify the percentage of results where HSAG 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 Over-Read

Objectives

The RAE 411 over-read evaluated each RAE's and DHMP's compliance with the Department's BH encounter data submission standards, as well as the consistency and accuracy with which each RAE and DHMP uses MRR to validate its BH encounter data. Figure 2-2 diagrams the high-level steps involved in HSAG's RAE 411 EDV over-read process, beginning in the upper left corner of the image.

Figure 2-2—FY 2021–2022 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' and DHMP's BH EDVs, including a specific timeline and file format requirements to guide each RAE and DHMP in preparing their 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, 2020, and June 30, 2021, from each RAE and DHMP region's BH encounter flat file for each of the following BH service categories: inpatient services, psychotherapy services, and residential services. The RAEs and DHMP 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' and DHMP's internal audit documentation and over-read each RAE's EDV results using MRR among a random sample of the RAE's and DHMP'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 and DHMP.

Description of Data Obtained

The Department used BH encounter data submitted by each RAE and DHMP to generate the 411 sample lists, and HSAG sampled the over-read cases from the 411 sample lists. Each RAE and DHMP were responsible for procuring medical records and supporting documentation for each sampled case, and the RAEs and DHMP used these materials to conduct their internal validation. Following their validation activities, each RAE and DHMP submitted a data file containing their 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 and DHMP'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' and DHMP's EDV responses. Results were analyzed by service category and encounter data element to review trends within the agreement rates.

How Conclusions Were Drawn

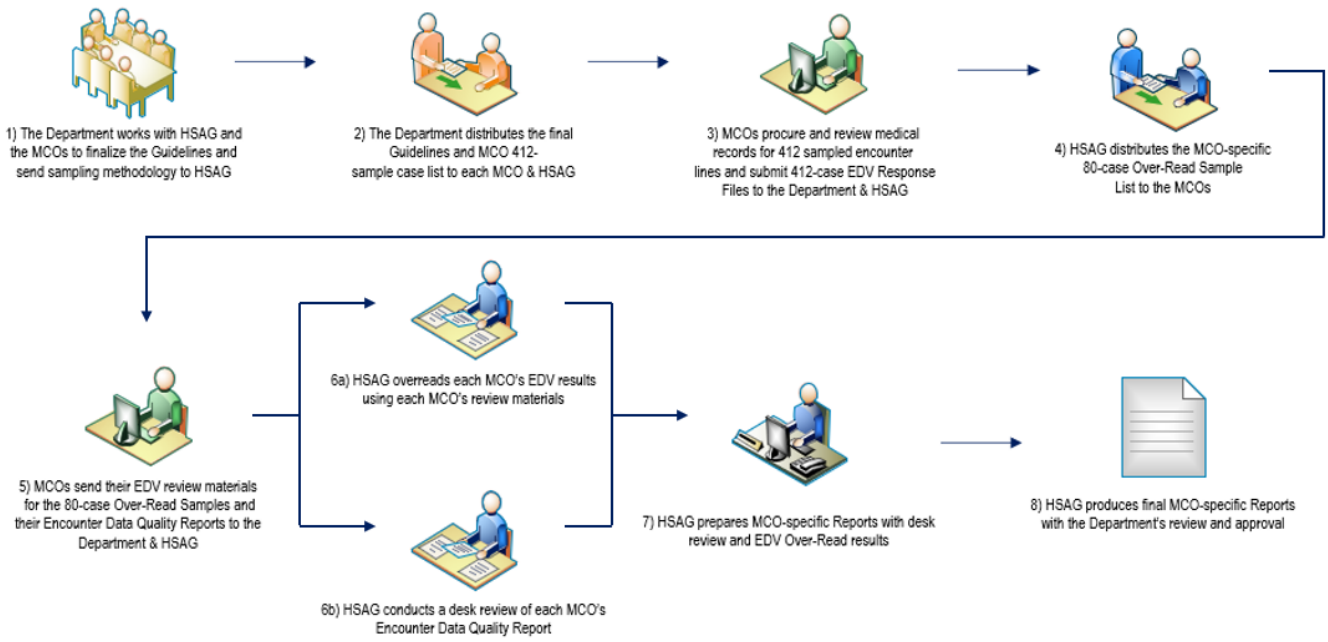
HSAG's over-read evaluated whether the RAEs' and DHMP's internal validation results were consistent with Colorado's Uniform Service Coding Standards (USCS) manuals and standard coding practices specific to the study period. Based on HSAG's level of agreement with each RAE's and DHMP's EDV results for the over-read cases, HSAG determined the extent to which the RAEs' and DHMP'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 2021–2022 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 encounters with dates of service from July 1, 2020, through June 30, 2021, and paid dates between July 1, 2020, and September 30, 2021. 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.

CAHPS Surveys—RAEs

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

The technical method of data collection for the RAEs occurred through the administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey with the HEDIS supplemental item set for the child population. HSAG administered the 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, 2021. Child members included as eligible for the survey were 17 years of age or younger as of October 31, 2021. All sampled adult members and parents/caretakers of sampled child members completed the surveys from

December 2021 to May 2022. 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 non-respondents 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 CAHPS survey included 40 items, and the child CAHPS survey included 41 items—all of which assess adult members' and parents'/caretakers' of child members perspectives on healthcare services. The survey questions were categorized into eight measures of experience, which 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 collected and aggregated the data attributed to the seven RAEs from survey respondents into a database for analysis. HSAG presents the FY 2021–2022 adult and child 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 measure, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the composite questions presented in the adult and child CAHPS 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."

How Data Were Aggregated and Analyzed

HSAG stratified the results by the seven RAEs. HSAG performed RAE comparisons of the results. Statistically significant differences between the RAEs' top-box responses and the Colorado RAE aggregate are noted with colored triangles. A RAE's top-box score that was statistically significantly higher than the Colorado RAE aggregate is noted with an upward green (▲) triangle. A RAE's top-box score that was statistically significantly lower than the Colorado RAE aggregate is noted with a downward red (▼) triangle. A RAE's top-box score that was not statistically significantly different than the Colorado RAE aggregate is not denoted with a triangle.

Also, HSAG performed comparisons of the results to the NCQA national averages. Statistically significant differences between the RAEs' top-box scores and the NCQA national averages are noted with arrows. A RAE's top-box score that was statistically significantly higher than the NCQA national average is noted with an upward green (↑) arrow. A RAE's top-box score that was statistically significantly lower than the NCQA national average is noted with a downward red (↓) arrow. A RAE'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 of, timeliness of, and access to services provided by the RAEs, 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 CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

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

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, which 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 2021–2022 scores were compared to their corresponding FY 2020–2021 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2021–2022 top-box scores and the FY 2020–2021 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in FY 2021–2022 than FY 2020–2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2021–2022 than FY 2020–2021 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 scores 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 of, 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
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

Quality Improvement Plans

Objectives

The purpose of conducting a QUIP is to improve encounter data accuracy. The QUIP is a structured QI activity that consists of three submission phases: process mapping and FMEA; FMEA priority ranking and proposed interventions; and outcomes, key findings, and conclusions. HSAG developed a template for each MCE to use as the submission document for each of the three phases of this project. HSAG pre-populated each MCE's template with the encounter data types found to be below 90 percent accuracy during the FY 2020–2021 RAE 411 or MCO 412 EDV audit.

Technical Methods of Data Collection

Phase 1: Process Mapping and FMEA

The MCEs developed a process map that aligned with the specific, internal steps involved for documenting and submitting each encounter data type to the Department. Within the process maps, the MCEs identified sub-processes or potential opportunities for improvement. These sub-processes were then used to develop FMEA tables. The MCEs selected three sub-processes from their process maps and identified several failure modes, failure causes, and failure effects for each. A failure mode is the specific way by which a failure could possibly occur within the context of the sub-process being evaluated. It is common to identify more than one failure mode for each sub-process. A failure cause is the MCE's suspected mechanism or reason that leads to the failure over time. A failure mode may have more than one cause. A failure effect is the consequence or result of a failure.

Phase 2: FMEA Priority Ranking and Proposed Interventions

MCEs reviewed their FMEA lists and ranked the priority level of failure modes from highest to lowest. From there, the MCEs determined interventions for those failure mode(s) ranked as highest priority. Each RAE considered the selected pilot partner based on baseline scores from the RAE 411 or MCO 412 EDV and outlined the number of charts to be reviewed for the QUIP. For each intervention, the MCEs noted considerations for reliability and sustainability. Reliability considers whether or not the intervention could be applicable across settings; sustainability considers whether or not the intervention could become a standard operating procedure without undue burden.

Phase 3: Outcomes, Key Findings, and Conclusions

After the proposed interventions were approved by HSAG, each MCE began implementing the interventions over a period of three months (November 2021 through January 2022, unless otherwise indicated) with a selected service agency or provider(s). Each month the MCE tracked the accuracy data percentage for each encounter data type. At the conclusion of the three-month evaluation period, each MCE submitted the outcome data for each encounter data type to HSAG with a narrative report, which included a fully completed QUIP submission form as well as a summary of the outcomes, key findings, and conclusions.

Description of Data Obtained

HSAG obtained the data needed to conduct the QUIP from each RAE 411 or MCO 412 EDV report from FY 2020–2021. Using these reports, HSAG compiled data for all MCEs with self-reported encounter data accuracy scores below 90 percent accuracy, which is the Department's threshold for required participation in the QUIP. The FY 2020–2021 RAE 411 or MCO 412 EDV self-reported accuracy scores were used as the baseline data for the FY 2021–2022 QUIP project and entered into the HSAG QUIP submission form templates and distributed for the MCEs.

For the RAE 411 EDV, data selected were derived from the following claim types: inpatient, ambulatory inpatient, psychotherapy, and residential services. Within each claim type, HSAG and the RAEs calculated accuracy rates for the following audit elements (encounter data types): *procedure code*, *service category modifier*, *diagnosis code*, *place of service*, *units*, *service start date*, *service end date*, *population*, *duration*, and *staff requirement*.

For the MCO 412 EDV, data selected were derived from the following four claim types: professional, inpatient, outpatient, and FQHC. Within each claim type, the MCOs calculated accuracy rates for the following audit elements (encounter data types): *procedure code*, *procedure code modifier*, *surgical procedure code*, *diagnosis code*, *units*, *date of service*, *through date*, and *discharge status*.

The MCEs used the QUIP submission form template to fill out information for phases 1, 2, and 3. During each phase, HSAG reviewed the submission and requested follow-up information or technical assistance calls to ensure adherence to the process, if needed.

How Data Were Aggregated and Analyzed

HSAG aggregated data across all RAEs in a RAE 411 QUIP aggregate report and compared the two MCOs in an MCO 412 QUIP aggregate report. For each aggregate report, HSAG analyzed at a high level if the QUIP was successful at improving accuracy for the RAEs and MCOs. HSAG prepared tables to display each MCE's QUIP outcomes and summarize the encounter data types that reached 90 percent accuracy or higher, and those that remained below the 90 percent threshold at the end of the QUIP.

How Conclusions Were Drawn

Based on the MCE's outcome data, HSAG evaluated the success of each MCE's intervention(s) and the extent to which the intervention(s) resulted in improved service coding accuracy. HSAG considered any existing barriers, fluctuations in accuracy scores month over month, and the sustainability and reliability of the intervention. A summary of recommendations were presented to the Department for the RAE 411 QUIP and MCO 412 QUIP in the form of an aggregate report and subsequently to each MCE in the form of a one-page recommendation summary.

Mental Health Parity Audits

Objectives

The purpose of conducting the MHP Audits is to annually review each Medicaid health plan's UM program and related policies and procedures, as well as review a sample of prior authorization denials to determine whether the health plans followed federal and State regulations and health plan internal policies and procedures.

Technical Methods of Data Collection

To assess whether the health plans demonstrated compliance with specified federal and State regulations, internal written policies and procedures, and organizational processes related to UM regulations, HSAG's assessment occurred in five phases:

1. Document Request
2. Desk Review
3. Telephonic Interviews
4. Analysis
5. Reporting

Description of Data Obtained

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

- UM program descriptions
- Policies and procedures, including policies or internal protocols that describe which inpatient and outpatient services require prior authorization
- UM Committee meeting minutes for the review period
- UR criteria used for each service type
- Records and pertinent documentation related to each adverse benefit determination (ABD) chosen

How Data Were Aggregated and Analyzed

HSAG compiled findings from data obtained by the health plans through the various methods of data collection including reviewing documents and records submitted during the desk review, telephonic interviews conducted with key UM staff members, and additional documents submitted as a result of the telephonic interviews. HSAG then calculated scores within a UM monitoring tool for inpatient and outpatient services for each record reviewed, an aggregate denial record review compliance score for each health plan, and an aggregate, statewide denials record review compliance score. The scores were then analyzed to look for patterns of compliance and noncompliance with UM regulations and compared to the previous review year to determine whether the health compliance scores showed an increase,

decline, or remained the same. The findings related to each health plan's compliance regulations, strengths, opportunities for improvement, and recommendations were compiled into a report for the Department.

How Conclusions Were Drawn

From the findings related to each health plan's compliance with UM regulations, HSAG was able to determine the health plan's strengths, opportunities for improvement, and provide recommendations to address the opportunities for improvement. All information gathered throughout the audit was compiled into a report for the Department that included an executive summary and appendix for each health plan to describe specific findings.

Quality of Care Concern Audit

Objectives

The QOCC Audit was designed as a focus study with the goal of providing information to the Department for use in improving monitoring and ultimately resulting in improving the health outcomes of Colorado's Medicaid populations.

Technical Methods of Data Collection

Each MCE was responsible for receiving, investigating, and resolving QOCCs brought to the MCE by members or their representatives and/or identified by the MCE. The review period was January 1, 2021, through December 31, 2021. To evaluate each MCE's process for managing, investigating, and resolving QOCCs during the review period, HSAG used the following:

- Document request
- Initial document review
- QOCC review
- Teleconference interviews
- Reporting

Description of Data Obtained

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

- Documents including policies and procedures, and any related desktop protocols or process documents
- Interviews with key MCE staff members conducted virtually
- Member and provider informational materials
- List of all substantiated QOCCs within the review period

- Random sampling case reviews and review materials for each case
- Definitions, including severity level definitions
- Qualifications of staff members investigating cases
- CAPs
- Regulatory agency reporting

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, the review of sample case reviews provided by each MCE, virtual interviews conducted with key personnel, and additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Definitions
- Number of substantiated cases reported during the review period
- Severity level definitions
- Qualifications of staff members investigating cases
- Case sample overview
- Adherence to internal policies and procedures
- Use of CAPs
- Regulatory agency reporting
- Recommendations

HSAG analyzed the results to identify strengths, opportunities for improvement, and recommendations. HSAG then identified common themes and the salient patterns that emerged across the MCEs related to QOCCs.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded a draft report to the Department for their review and comment prior to issuing final reports.

How Conclusions Were Drawn

To draw conclusions, HSAG developed an audit to gather information regarding the processes for how each MCE addressed QOCCs. Additionally, all submitted documentation, which included policies, procedures, and related documents, was reviewed to draw conclusions and to understand each MCE's standard procedures for addressing QOCCs.

EQR Dashboard

Objectives

The EQR Dashboard was designed to allow the Department to monitor and track the MCEs' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, MHP Audit compliance scores, and PIPs.

Technical Methods of Data Collection

Data were gathered for performance measures, CAHPS, compliance audits, MHP Audit compliance scores, and PIPs as detailed in their respective EQR sections of this technical report.

Description of Data Obtained

HSAG obtained the results needed to populate the dashboard from other EQR activities including performance measures, CAHPS, compliance audits, MHP Audit compliance scores, and PIPs.

How Data Were Aggregated and Analyzed

Performance measures and CAHPS results were evaluated together to form an overall summary score. This information was displayed along with compliance scores, MHP Audit compliance scores, and PIPs to allow users to assess plan performance across a number of different EQR activities at a glance.

HSAG developed the following two dashboards:

- **Compare Plans Overall, by Domain, and by Measure**—allows the user to select a program (i.e., CHP+, Medicaid, RAE) and review how all MCEs within the program performed at a high level.
- **Plan Rating Review**—this view provides MCE-level results for all domains, measures, and indicators. This view also includes the ranking information to identify how the selected MCE compares to others in its program and additional insight on areas that may warrant focus.

These dashboards allow the user to assess plan performance on performance measures and/or CAHPS at different levels of aggregation (domain, measure, indicator) to facilitate identification of high and lower performers.

How Conclusions Were Drawn

Users may click on an exclamation mark icon in the Plan Rating Review Dashboard that will show an additional interactive screen where the user can select criteria to see a list of low-performing measures, which may provide opportunities for improvement or high-performing measures. The user can use one or more of the criteria: decrease in performance from year to year, performance relative to NCQA benchmarks, and below the statewide average. The user can also set the threshold to use for each of the criteria. An additional table will populate with measures meeting the selected criteria.

Aggregating and Analyzing Statewide Data

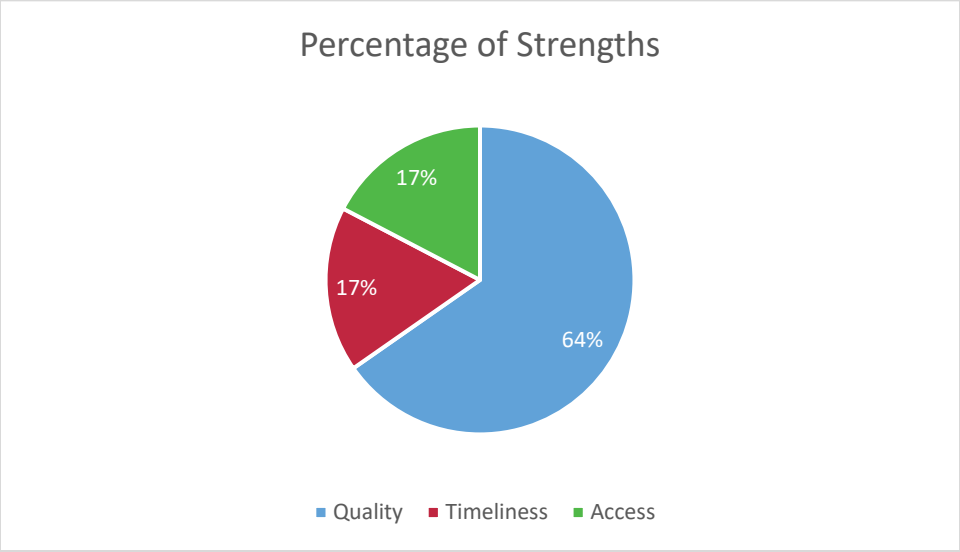
For each health plan, HSAG analyzed the results obtained from each EQR mandatory and optional activity conducted in FY 2021–2022. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality 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

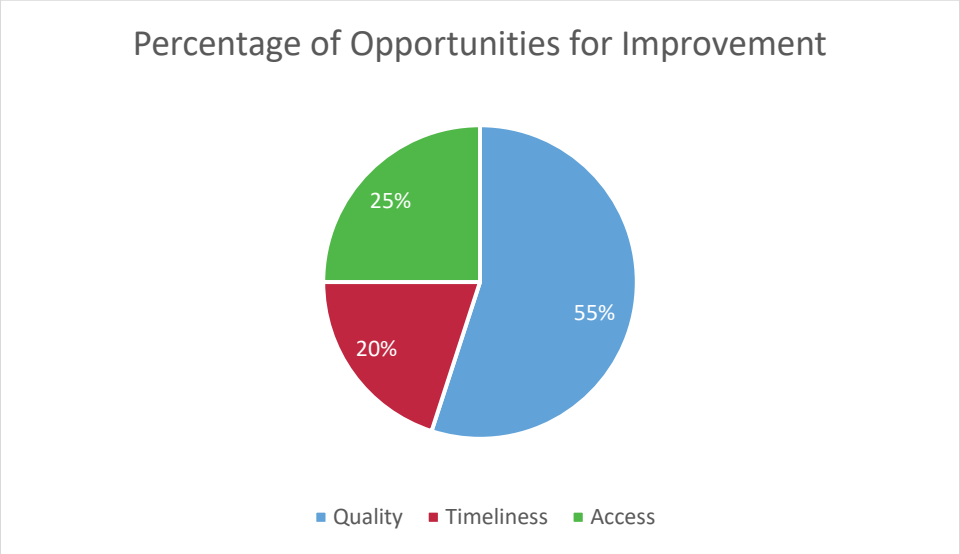
Region 1—Rocky Mountain Health Plans

Figure 3-1—Percentage of Strengths by Care Domain for RMHP*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-2—Percentage of Opportunities for Improvement by Care Domain for RMHP*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are RMHP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, RMHP established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-1 and Table 3-2 summarize RMHP's PIP activities that were completed and validated in FY 2020–2021. Table 3-1 provides the SMART Aim statements that RMHP defined for the two PIP outcome measures in Module 1.

Table 3-1—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for RMHP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, RMHP will partner with St. Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE members attributed to either SMFM or MFHC ages 12 years or older, from 0.63% to 20.00%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement*	By June 30, 2022, RMHP will partner with SMFM and MFHC 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 ages 12 years or older, from 28.57% to 46.89%.

**The SMART Aim statement was revised in June 2021. HSAG approved revisions to the SMART Aim statement in June 2021 in response to RMHP's correction of data queries used to produce the baseline percentage.*

Table 3-2 summarizes the preliminary key drivers and potential interventions RMHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-2—Preliminary Key Drivers and Potential Interventions 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 need follow-up behavioral services.

FY 2021–2022 PIP Activities

In FY 2021–2022, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, RMHP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, RMHP submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as RMHP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-3 presents the FY 2021–2022 Module 3 validation findings for RMHP's four interventions.

Table 3-3—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Develop, implement, and train medical assistants (MAs) and providers on a new workflow to score, document, and correctly code depression screens with a negative result (G8510) and positive result (G8431)	• MA does not calculate score and submit to superbill • PHQ-2/PHQ-9 is scored and billed incorrectly	• Provider, care team, and billing/coding education regarding proper coding of positive and negative depression screen for RAE	• Percentage of depression screenings completed for RAE members by MFHC for which a negative depression screen coded G8510 was submitted for billing • Percentage of depression screenings completed for RAE members by MFHC for which a positive depression screen coded G8431 was submitted for billing
Develop and deploy a registry for patients who score positive on PHQ-9 to guide behavioral health advocates (BHAs) to connect to patients for BH follow-up when appropriate	• Patient has a positive PHQ-9 but PHQ-9 report does not accurately capture all patients • Community BH providers not accepting new patients • Patient does not prioritize BH visit as part of medical services	• Implement PHQ strategy for follow-up interaction with patients who screen positive for depression	• Percentage of RAE members with a positive depression screen coded G8431, referred to BH services using the PHQ-9 report, who scheduled a follow-up visit with BHA within 30 days of positive screen
Integrate G-codes into workflow to ensure proper measurement capture of G8431 and G8450. Review and revise SMFM workflow for using G-codes	• Depression screening occurred but was not billed for • Providers could not code	• Use G-codes when screening for depression	• Percentage of RAE members seen by the partner provider who were screened for depression and had the appropriate G-code entered in the data system • Percentage of positive depression screen (G8431) claims for RAE members submitted by the partner provider that were paid • Percentage of negative depression screen (G8510) claims for RAE members

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
			submitted by the partner provider that were paid
Create a standardized depression screening billing and CPT coding workflow for the partner provider	• Code is not entered	• Bill for follow-up	• Percentage of RAE members seen by the partner provider who received a PHQ score of 8 or higher and for whom at least one BH intervention code was billed

In Module 3, RMHP selected four interventions to test for the PIP. The interventions addressed process gaps or failures in clinic workflows, coding, and billing practices for depression screening and follow-up services. For each intervention, RMHP defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, RMHP continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- Selected four interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of four interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. RMHP addressed all Module 3 PIP validation criteria.

To support successful progression of RMHP's PIP in the next fiscal year, HSAG recommends:

- RMHP collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- RMHP ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, RMHP should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, RMHP should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-4 shows the performance measure results for RMHP for MY 2019 through MY 2021.

Table 3-4—Performance Measure Results for RMHP

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	49.58%	41.72%	47.90%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.15%	47.66%	44.48%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	27.75%	30.85%	32.46%	48.22%
Follow-Up After a Positive Depression Screen	44.87%	51.47%	57.49%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.29%	13.57%	16.39%	30.56%

RMHP: Strengths

The following performance measure rates for MY 2021 increased from the previous year for RMHP:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

To address these opportunities for improvement, HSAG recommends RMHP:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Overall Evaluation

Table 3-5 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 2021–2022.

Table 3-5—Summary of RMHP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	18	16	2	0	0	89%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**39**	**2**	**0**	**0**	**95%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-6—Compliance With Regulations—Trended Performance for RMHP

Standard and Applicable Review Years*	RMHP Average—Previous Review	RMHP Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	90%	
Standard II—Adequate Capacity and Availability of Services (2019–2020)	100%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**100%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**86%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**83%**	**89%**
Standard VI—Grievance and Appeal Systems (2019–2020)	86%	

Standard and Applicable Review Years*	RMHP Average—Previous Review	RMHP Average—Most Recent Review**
Standard VII—Provider Selection and Program Integrity (2020–2021)	94%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**100%**	**100%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, each of the four standards reviewed for RMHP showed consistent high-achieving or improved scores from the previous review year, indicating a thorough understanding of most federal and State regulations.

RMHP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP conducted targeted outreach for care coordination toward members that were high-risk prenatal and postnatal, members identified by the Colorado Overutilization Program (COUP), and members in the top 2.8 percent risk group during stratification.
- RMHP outlined a procedure for timely efforts to conduct new RAE member welcome calls within 60 days. The welcome calls introduced the member to RMHP, provided information about care coordination services, identified any continuity of care needs for members, and included an initial health screening. RMHP reported a success rate of 25 to 30 percent in completing the initial screening during the welcome call.
- RMHP delineated the rights of the members through various channels such as the *Getting Started Guide*, provider manual, provider agreements and contracts, regular trainings, email reminders, provider and member newsletters, and RMHP's website.
- RMHP's member-specific webpages contained minimal to no errors and downloadable PDFs met Section 508 compliance requirements.
- RMHP made efforts to provide members with information about EPSDT services within 60 days of enrollment, which included the member handbook, *Getting Started Guide*, welcome calls, and screening assessments. Throughout the year, RMHP distributed additional reminders regarding

EPSDT services such as educational fliers, annual EPSDT member notifications, care gap outreach in the form of letters and phone calls, peripheral communications on social media platforms, and other age-specific material.

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

HSAG found the following opportunities for improvement:

- RMHP did not send any follow-up information to members after the outreach call detailing the care coordination information provided over the phone to the member.
- Critical informational materials did not include all required components of a tagline, some member informational and supplemental materials tested above the required sixth-grade reading level, and RMHP did not consistently inform members that information provided electronically is available in paper form "within five business days" on its websites. Additionally, policies did not have current federal language regarding the timeline to notify members of provider termination, which was updated in December 2020 to include "or 30 days prior to the effective date of termination."
- RMHP's documents did not clearly explain that EPSDT services are available to members ages 0 to 20, at no cost (with certain exceptions), and did not contain full details regarding the definition of "medical necessity." RMHP staff members were limited to EPSDT desktop references and current resources to make referrals with State health agencies and programs. Furthermore, RMHP submitted limited documentation to verify how EPSDT considerations are processed within the UM department.

To address these opportunities for improvement, HSAG recommends RMHP:

- Consider sending a follow-up letter to the member detailing the information provided during the care coordination outreach call.
- Enhance monitoring mechanisms to ensure all required member informational materials are at the sixth-grade reading level, to the extent possible; revise critical informational materials to include all required components of a tagline; align information consistently across websites to include that information provided electronically is available in paper form and provided to the member within five business days; and update the applicable policy to include "or 30 days prior to the effective date of the termination" when notifying the member of provider termination.
- Clarify EPSDT documents to include that EPSDT services are available, at no cost, for all members ages 20 and under. Additionally, clarify within the provider manual that, while some services are not within the RMHP benefit, the EPSDT services are covered under the Health First Colorado benefit and medically necessary services are not at the convenience of the caretaker/parent/guardian, provider, or member. Furthermore, expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process.

Validation of Network Adequacy

RMHP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP met all minimum standards for Adult Primary Care (MD, DO, NP, CNS), General BH and Pediatric BH, and General Psychiatrist and Pediatric Psychiatrist across all contracted counties.

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

HSAG found the following opportunities for improvement:

- RMHP did not meet the minimum time and distance network requirements for Psychiatric Hospitals across all contracted counties. Gynecology OB/GYN (MD, DO, NP, CNS), Gynecology OB/GYN (PA), and SUD ASAM levels did not meet the minimum time and distance network requirement across multiple contracted counties.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends RMHP:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-7 presents RMHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-7—FY 2021–2022 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	59.9%	38.7%
Principal Surgical Procedure Code	87.6%	NA	NA
Diagnosis Code	73.7%	61.3%	38.7%
Place of Service	NA	55.5%	29.9%
Service Category Modifier	NA	64.2%	35.0%
Units	NA	60.6%	38.7%
Revenue Code	73.7%	NA	NA

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Discharge Status	78.1%	NA	NA
Service Start Date	80.3%	64.2%	38.7%
Service End Date	80.3%	64.2%	38.7%
Population	NA	64.2%	38.7%
Duration	NA	60.6%	38.7%
Staff Requirement	NA	62.8%	33.6%

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

Table 3-8 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 3-8—FY 2021–2022 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	100.0%	60.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	80.0%	60.0%
Place of Service	NA	90.0%	60.0%
Service Category Modifier	NA	100.0%	60.0%
Units	NA	90.0%	60.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	80.0%	90.0%	60.0%
Service End Date	90.0%	90.0%	60.0%
Population	NA	90.0%	60.0%
Duration	NA	100.0%	60.0%
Staff Requirement	NA	90.0%	60.0%

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

RMHP: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- 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 four of the six validated data elements within the inpatient services category and three of the 10 validated data elements within the psychotherapy services category.

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

HSAG found the following opportunities for improvement:

- Due to incomplete documentation, HSAG's reviewers agreed with only 60 percent of over-read cases for all 10 validated data elements within the residential services category, and the reported accuracy rates were under 39 percent for all categories.

To address the opportunities for improvement, HSAG recommends RMHP:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

RMHP: Adult CAHPS

Table 3-9 shows the adult CAHPS results for RMHP for FY 2021–2022.

Table 3-9—FY 2021–2022 Adult CAHPS Top-Box Scores for RMHP

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	59.6%	55.2% ↓
Rating of All Health Care	60.8%	56.5%
Rating of Personal Doctor	72.1%	66.2%
Rating of Specialist Seen Most Often	71.4%+	69.2%
Getting Needed Care	80.6%+	80.9%
Getting Care Quickly	77.4%+	78.9%
How Well Doctors Communicate	90.6%+	91.3%
Customer Service	85.1%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

RMHP: Strengths

The following measures' FY 2021–2022 scores for RMHP were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

The following measures' FY 2021–2022 scores for RMHP were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

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

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

The following measures' FY 2021–2022 scores for RMHP were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*

The following measures' FY 2021–2022 scores for RMHP were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends RMHP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.
- Assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

RMHP: Child CAHPS

Table 3-10 shows the child CAHPS results for RMHP for FY 2021–2021.

Table 3-10—FY 2021–2022 Child CAHPS Top-Box Scores for RMHP

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	68.4%	70.8%
Rating of All Health Care	66.1% ↓	65.1% ↓
Rating of Personal Doctor	78.8%	76.1%
Rating of Specialist Seen Most Often	59.2%+	70.9%
Getting Needed Care	77.7%+	80.2% ↓
Getting Care Quickly	85.1%+	84.9%
How Well Doctors Communicate	93.2%	93.6%
Customer Service	83.8%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

RMHP: Strengths

The following measure's FY 2021–2022 score for RMHP was higher, although not statistically significantly, than the 2021 NCQA national average:

- *Rating of Personal Doctor*

The following measures' FY 2021–2022 scores for RMHP were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Getting Care Quickly*

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

The following measure's FY 2021–2022 score for RMHP was statistically significantly lower than the 2021 NCQA national average:

- *Rating of All Health Care*

The following measures' FY 2021–2022 scores for RMHP were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends RMHP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Quality Improvement Plan

Table 3-11 presents RMHP's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-11—Summary of RMHP QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Inpatient	Diagnosis Code	71%	87%	93%	93%
	Revenue Code	75%	100%	100%	100%
	Service End Date	89%	93%	100%	100%
Psychotherapy	Procedure Code	47%	100%	93%	100%
	Diagnosis Code	31%	100%	87%	100%
	Place of Service	42%	67%	67%	67%
	Service Category Modifier	47%	100%	100%	100%
	Units	47%	100%	100%	87%
	Service Start Date	52%	67%	67%	67%
	Service End Date	52%	67%	67%	67%
	Population	50%	100%	100%	100%
	Duration	47%	100%	100%	87%
	Staff Requirement	48%	67%	73%	80%
Residential Services	Diagnosis Code	82%	87%	87%	87%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

RMHP: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- All encounter data accuracy increased from baseline and all inpatient encounter data types and some psychotherapy encounter data types (specifically *procedure code*, *diagnosis code*, *service category modifier*, and *population* encounter data types) reached or exceeded 90 percent accuracy.

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

HSAG found the following opportunities for improvement:

- Half of RMHP's encounter data accuracy rates remained below the 90 percent target threshold for accuracy. Psychotherapy *place of service*, *service start date*, and *service end date* reached only 67 percent accuracy at the end of the QUIP.

To address these opportunities for improvement, HSAG recommends RMHP:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-12 displays the MHP Audit compliance scores for RMHP for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-12—FY 2021–2022 MHP Audit Score for RMHP

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
RMHP	1	100%	Inpatient	86%	91%v
			Outpatient	96%	

v *Indicates that the score declined as compared to the previous review year.*

RMHP: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP used nationally recognized UR criteria, including MCG criteria, for all MH determinations and ASAM level of care criteria for all SUD determinations.
- RMHP followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually, including requiring an 80 percent passing score.

- RMHP followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization and requirements for processing requests for services within all files reviewed.
- For all 10 inpatient and 10 outpatient denial determinations, each determination was based on established authorization criteria.
- In all cases reviewed, denial determinations were made by a qualified clinician.
- All NABDs were written at a reading level that was easy for the member to understand.
- During the MHP interview, RMHP reported several best practices related to implementation of the new SUD inpatient and residential benefit package starting in 2021, including monthly training opportunities for providers, provider communications to assist providers in understanding the new SUD benefits, utilizing the state-developed uniform request form for SUD services, and reporting the SUD care coordinator is a member of the UM team to ensure that members receive the appropriate level of care when a particular level of care is denied.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- RMHP did not always send the NABD to the member within the required time frame.
- RMHP often only sent the NABD using the provider template to the provider, with a copy to the member. Additionally, the NABD provider template that was often sent to the member did not include all required content. During the MHP interview, RMHP staff members reported that during calendar year (CY) 2021, it was standard practice to only send a provider letter (with a copy to the member) for denials determined via a concurrent review.
- RMHP did not consistently offer or have documentation to support that peer-to-peer review was offered to the requesting provider prior to finalizing a denial determination.

To address these opportunities for improvement, HSAG recommends RMHP:

- Develop and implement ongoing staff training and monitoring to ensure adherence to required time frames.
- Enhance monitoring mechanisms to ensure the correct NABD template is sent to the member and includes all required content.
- Evaluate documentation protocols to ensure accuracy of documenting whether peer-to-peer reviews were offered.

Quality of Care Concern Audit

RMHP used CMS' definition of a QOCG. RMHP submitted a *Retrospective Quality Case Review Process Policy and Procedure* for review. However, the RAEs' definition for QOCG is not stated in policy. RMHP had a total of 17 substantiated cases reported during the review period and used a four-level rating system to define the severity of QOCGs. RMHP's *Retrospective Quality Case Review Process Policy and Procedure* did not define the severity levels. However, RMHP submitted a *Semi-Annual Evaluation Quality of Care* report dated July 1, 2021, through December 31, 2021, that included definitions for each severity level. Professionals with varying qualifications and/or degrees reviewed QOCGs submitted to RMHP.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, seven were non-Hispanic White members.
- One out of 10 members was disabled.
- Six cases had a severity level of moderate, two were minor, and two were severe.
- Eight out of 10 cases were related to the quality of mental health service, with seven of those being a facility issue.
- Three out of 10 case outcomes resulted in a CAP for the provider/facility.

RMHP had a system for identifying and addressing all alleged QOCGs. When a concern was raised, RMHP investigated, analyzed, tracked, trended, and resolved QOCGs according to policy. RMHP adhered to an RMHP policy titled *Retrospective Quality Case Review Process Policy and Procedure*. In addition to the policy, the RAE adhered to a *Quality-of-Care Workflow* developed by RMHP. The workflow provided direction for handling and reviewing QOCGs. Based on review of 10 sample cases and associated documents, HSAG determined that RMHP adhered to its internal policies and procedures.

None of the 10 sample cases reviewed had outcomes reported to a regulatory agency or licensing board. RMHP's policy stated that, if needed, the RAE would report any unethical or member safety issues described within the Mental Health Practice Act to the Colorado Department of Regulatory Agencies (DORA) to investigate. The psychiatric medical director (PMD) will report all wrongful or unlawful conduct to the Medical Board immediately after review. Additionally, the workflow chart included a step for notifying RMHP's legal department.

RMHP: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP's QI program included activities that improve the quality and safety of clinical care and BH services for members. As appropriate, interventions and follow-up for identified QOC issues were developed for the cases reviewed. Policies described a process whereby a QI case reviewer, medical

director, and a QI case review team would investigate, analyze, track, trend, and resolve QOCGs.

- The *Health First Colorado Member Handbook* and information on the RAE's website included information for the member about the process for reporting a grievance. The member materials did not distinguish the difference between a grievance and a QOCG. By means of internal investigation and utilizing the QOCG definition, the grievance team could make a referral to the QI case review team to investigate grievances deemed a potential QOCG.
- The provider manual included information for reporting issues such as adverse events and sentinel events. Within the RMHP provider manual, providers were reminded that all member records requested and referred to the QI case review team would be kept strictly confidential through the entire case referral and review process. During the interview, RMHP staff members stated that RMHP held a seminar for all providers to review the process for reporting sentinel events and to implement the use of a newly developed standardized form for reporting sentinel events to RMHP.
- As needed, and according to policy, RMHP reviewed QOCGs with the following:
  - Medical Advisory Council (MAC)
  - Medical Practice Review Committee (MPRC)
  - Credentialing Committee
  - RMHP's legal department
  - Clinical Advisory Quality Improvement (CAQI) provider workgroup
- RMHP's policy included information for querying its quality assurance (QA) database semiannually to identify the number of QOCG cases. Policies and procedures indicated that results are reported to the MAC for review, analysis, and follow-up as needed. The QA database was also queried semiannually for trend analysis. The RAE provided evidence of a MAC report dated July 1, 2021, through December 31, 2021. The *Semi-Annual Evaluation Quality of Care* report provided severity level definitions, the number of QOC cases by level of concern, the number of incoming QOC cases, the type of case, the number of readmission cases, a quality analysis summary, a quantitative analysis, interventions, and opportunities for improvement.
- Starting in quarter one of CY 2022, RMHP began proactively reporting QOCGs to the Department. Historically, RMHP was only reporting to the Department if the Department requested a report or if a severe or systemic concern was identified. RMHP would also notify the Department if a network provider was terminated.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

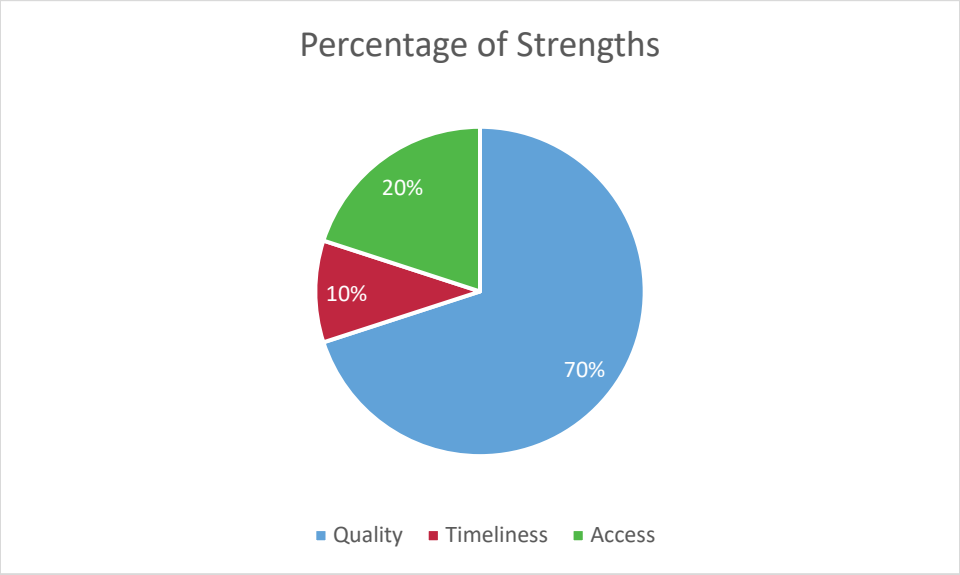
- While the RAE had a policy and procedure that described a retrospective quality case review process, it lacked detail about letter templates, the acknowledgement and resolution letter process, contract requirements, assigning a severity level, and the CAP process. All QOCGs submitted were reviewed by a medical director. Additionally, during the interview, RMHP staff members reported that there are questions regarding whether RMHP should conduct QOCGs that are related to dental services since RMHP is not the payor for dental services.
- RMHP staff members reported that the QI case review team and grievance team work in tandem if the grievance is reported by a member/member advocate for sending out acknowledgment and resolution letters. The sample cases that resulted in a CAP had a resolution letter; however, acknowledgement and resolution letters were not present for each sample case reviewed and a process was not outlined in RMHP's *Retrospective Quality Case Review Process Policy and Procedure*. RMHP staff members stated that evidence of the two facility-imposed CAPs reviewed in the case sample had an attestation from the facility/provider stating that the CAP was implemented and completed.
- At the time of this audit, RMHP did not have timelines or time frames for completing the QOCG process. During the interview, staff members indicated that each QOCG they investigate is unique and it would be difficult to establish timelines or time frames for the process. However, RMHP staff members stated during the interview that they try to follow internal unofficial timelines. Staff members indicated that they would request guidance from the Department for establishing timelines, time frames, and/or goals for handling QOCGs.
- During the interview, RMHP staff members stated that if throughout the review and investigation of a QOCG follow-up with a member needed to occur to ensure the member's immediate healthcare needs were met, the QI case reviewer would request that the care coordination team outreach to the member. None of the sample cases reviewed provided evidence that a care coordinator spoke with a member to ensure their immediate healthcare needs were met. Neither RMHP's policy nor workflow chart described this step in the process.
- RMHP staff members stated that the customer service team received training on what constitutes a QOCG. At the time of the QOCC Audit, RMHP reported working on updating the training materials.

To address these opportunities for improvement, HSAG recommends RMHP:

- Develop and implement ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Provide step-by-step procedures for identifying, investigating, addressing, analyzing, tracking, trending, resolving, and reporting QOCGs.
  - Incorporate contract requirements.
  - Add severity levels and definitions.
  - Include a process for reporting to the Department.
  - Incorporate a process for acknowledgment and resolution letters.
  - Establish milestones/timelines/time frames and/or goals for the QOCG process.
- Consider consistently requesting evidence of CAP completion from a facility/provider when a CAP is initiated. For example, if the facility indicated that they revised a policy and provided staff training, RMHP could request a copy of the updated policy, training materials, and list of attendees.
- Continue notifying the Department of QOCGs received. Additionally, RMHP should continue reaching out to the Department to report ad hoc cases with severity rating, systematic concerns, and termination of any network provider.
- Continue to work in tandem with the grievance team to send out acknowledgment and resolution letters to members, along with consistent documentation to capture these letters. RMHP could establish a process for sending acknowledgment and resolution letters to the party reporting the QOCG for all QOCGs, regardless of who reported the QOCG referral.
- Follow up with its contract managers at the Department to resolve questions regarding whether RMHP should conduct QOCGs that are related to dental services since RMHP is not the payor for dental services.

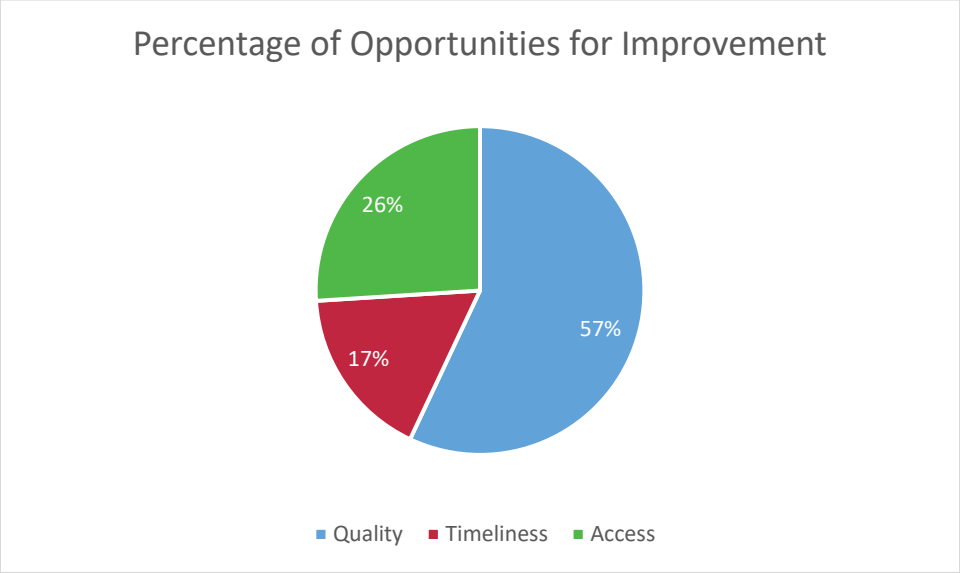
Region 2—Northeast Health Partners

Figure 3-3—Percentage of Strengths by Care Domain for NHP*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-4—Percentage of Opportunities for Improvement by Care Domain for NHP*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are NHP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, NHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, NHP established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-13 and Table 3-14 summarize NHP's PIP activities that were completed and validated in FY 2020–2021. Table 3-13 provides the SMART Aim statements that NHP defined for the two PIP outcome measures in Module 1.

Table 3-13—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for NHP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 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 June 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%.

Table 3-14 summarizes the preliminary key drivers and potential interventions NHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-14—Preliminary Key Drivers and Potential Interventions 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. • 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 BH providers. • Closing BH referral communication loop.
Potential Interventions	• Develop process flow for communicating positive depression screens to targeted BH provider. • Develop process flow for referral loop communication between targeted primary care and BH providers. • Capture BH follow-up service on well visit claim for same-day services.

FY 2021–2022 PIP Activities

In FY 2021–2022, NHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, NHP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, NHP submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as NHP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-15 presents the FY 2021–2022 Module 3 validation findings for NHP's two interventions.

Table 3-15—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Staff feedback on depression screening performance and training on depression screening procedures	MA skips PHQ-4 during check-in process without medical rationale	MA training/awareness of depression screening impact	Percentage of eligible outpatient encounters at Sunrise Clinic (MFC) during which a depression screen was conducted, as captured in the EHR
Establish a clinical policy for BH referral after a positive depression screen and provide staff training on BH referral policy and procedures following a positive depression screen	Provider addresses positive depression screen with a follow-up plan and/or psychopharmacology without BH provider involvement	Timely communication with BH providers following positive depression screen	Percentage of members with a positive depression screen at Valley-Wide Clinic who have a follow-up BH service within 30 days of the positive screen

In Module 3, NHP selected two interventions to test for the PIP. The interventions addressed process gaps or failures in staff training, and clinical policies and procedures for depression screening and follow-up after a positive depression screen. For each intervention, NHP defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, NHP continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- Selected two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. NHP addressed all Module 3 PIP validation criteria.

To support successful progression of NHP's PIP in the next fiscal year, HSAG recommends:

- NHP collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- NHP ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, NHP should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, NHP should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-16 shows the performance measure results for NHP for MY 2019 through MY 2021.

Table 3-16—Performance Measure Results for NHP

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	46.40%	42.34%	50.80%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	64.31%	74.23%	50.07%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	38.33%	39.25%	29.64%	48.22%
Follow-Up After a Positive Depression Screen	50.00%	53.25%	87.09%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	15.76%	23.00%	18.60%	30.56%

NHP: Strengths

The following performance measure rates for MY 2021 increased from the previous year for NHP:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up After a Positive Depression Screen*

Additionally, the following performance measure rate for MY 2021 exceeded the performance measure target:

- *Follow-Up After a Positive Depression Screen*

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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

To address these opportunities for improvement, HSAG recommends NHP:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

NHP Overall Evaluation

Table 3-17 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 2021–2022.

Table 3-17—Summary of NHP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	14	12	2	0	4	86%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**37**	**34**	**3**	**0**	**4**	**92%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-18—Compliance With Regulations—Trended Performance for NHP

Standard and Applicable Review Years*	NHP Average—Previous Review	NHP Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	97%	
Standard II—Access and Availability (2019–2020)	94%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**91%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**100%**	**86%**
Standard VI—Grievance and Appeal Systems (2019–2020)	77%	

Standard and Applicable Review Years*	NHP Average—Previous Review	NHP Average—Most Recent Review**
Standard VII—Provider Selection and Program Integrity (2020–2021)	94%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	94%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**100%**	**86%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, NHP demonstrated consistent high-achieving or improved scores for Standard III—Coordination and Continuity of Care and Standard IV—Member Rights, Protections, and Confidentiality compared to the previous review year. However, Standard V—Member Information Requirements and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services both showed a decline in scores by 14 percentage points compared to the previous review year.

NHP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for NHP:

- NHP members were able to enter care coordination in various ways such as through the call center by speaking to a customer service agent; referrals from community agencies and other RAEs; data workflow through Department-identified members with complex and chronic conditions needing care coordination services; the daily admission, discharge, and transfer (ADT) feed; and the *Health Needs Survey*.
- NHP had a policy that described procedures and guidelines to employees, contractors, and network providers for the uses and disclosures of protected health information (PHI). Additionally, NHP purchased the Zoom for Healthcare platform and obtained Health Insurance Portability and Accountability Act of 1996 (HIPAA) certificates for Zoom to ensure privacy measures for providers that transitioned to telework.
- NHP organized educational forums and a texting campaign designed to help members understand the requirements and benefits of the plan. The text message scripts included information such as member handbook information, website link information, well-child visit reminders, the nurse advice line number, member rights, advance directives, vaccinations, BH, crisis services, and how to get an insurance card.

- NHP and Beacon Health Options (Beacon) (NHP's administrative service organization [ASO]) staff members attended local meetings, such as county Department of Health Services and Children's Disability Advisory Committee (CDAC) meetings, to increase awareness about EPSDT.

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

HSAG found the following opportunities for improvement:

- NHP's policies, procedures, and delegate agreements did not clearly illustrate the roles, responsibilities, and monitoring in place for all those involved in NHP's multi-tiered care coordination delegation model.
- Some member-specific websites contained contrast error issues related to accessibility issues and Section 508 compliance, critical member materials did not include all the required components of a tagline, and NHP did not consistently inform members that information provided electronically to members is available in paper form "within five business days" on its websites. NHP's documents did not include information about its website to meet all required member information components.
- Although NHP's quarterly outreach reports indicated a low success rate for completions, NHP did not include voicemails in this overall count. Additionally, the EPSDT Tip Sheet did not follow American Academy of Pediatrics *Bright Futures Guidelines* time frames for recommended teen well visits. NHP did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period, and annual outreach solely relied on text message outreach to members.

To address these opportunities for improvement, HSAG recommends NHP:

- Expand the language in the applicable policies, procedures, and delegate agreements to better illustrate the roles, responsibilities, and monitoring in place for all those involved in NHP's multi-tiered care coordination delegation model.
- Expand procedures and reporting mechanisms to address, prioritize, and rectify contrast issues relating to accessibility and Section 508 compliance; revise critical member materials to include all required components of a tagline; and develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days. HSAG also recommends ongoing communication with the Department and NHP to ensure the updated welcome letter includes all required components such as NHP's website address.
- Verify the definition of "completed" outreach with the Department and further explore the addition of voicemails in upcoming quarterly outreach reports, update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* time frame for annual well visits, and enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.

Validation of Network Adequacy

NHP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- While NHP did not meet all minimum time and distance network requirements across all counties in each county designation, General BH Practitioners, General Psychiatrist and Pediatric Psychiatrist, and Pediatric Primary Care Practitioners (MD, DO, NP, CNS) had only one county that did not meet the standard by 1 percent.

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

HSAG found the following opportunities for improvement:

- NHP did not meet the minimum time and distance network requirements for Gynecology OB/GYN (MD, DO, NP, CNS), Gynecology OB/GYN (PA), Psychiatric Hospitals and SUD treatment facilities for more than half of the contracted counties.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends NHP:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-19 presents NHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-19—FY 2021–2022 Self-Reported EDV Results by Data Element and BH Service Category for NHP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	97.8%	100%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	93.4%	98.5%	100%
Place of Service	NA	67.9%	100%
Service Category Modifier	NA	98.5%	100%
Units	NA	98.5%	100%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Revenue Code	100%	NA	NA
Discharge Status	100%	NA	NA
Service Start Date	100%	97.8%	100%
Service End Date	100%	97.8%	100%
Population	NA	98.5%	100%
Duration	NA	97.8%	100%
Staff Requirement	NA	98.5%	100%

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

Table 3-20 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 3-20—FY 2021–2022 BH EDV Over-Read Agreement Results by BH Service Category for NHP

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	80.0%	100.0%	100.0%
Service End Date	90.0%	100.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	100.0%	100.0%

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

NHP: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- NHP self-reported high overall accuracy for the 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 reviewers agreed with the inpatient services EDV results for 100 percent of the over-read cases for four of the six validated data elements.
- At 100 percent, the *principal surgical procedure code*, *diagnosis code*, *revenue code*, and *discharge status* data elements had the highest rates of agreement between NHP's inpatient services EDV results and HSAG's over-read results.
- HSAG's reviewers agreed with the psychotherapy services and residential services EDV results for 100 percent of the over-read cases for all 10 validated data elements.

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

HSAG found the following opportunities for improvement:

- For the *place of service* data element for psychotherapy services, NHP's self-reported EDV results demonstrated a low level of encounter data accuracy at 67.9 percent when compared to the corresponding medical records.

To address the opportunities for improvement, HSAG recommends NHP:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

NHP: Adult CAHPS

Table 3-21 shows the adult CAHPS results for NHP for FY 2021–2022.

Table 3-21—FY 2021–2022 Adult CAHPS Top-Box Scores for NHP

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	56.5%+	55.2% ↓
Rating of All Health Care	53.3%+	56.5%
Rating of Personal Doctor	72.7%+	66.2%
Rating of Specialist Seen Most Often	72.2%+	69.2%
Getting Needed Care	81.3%+	80.9%
Getting Care Quickly	80.4%+	78.9%
How Well Doctors Communicate	92.2%+	91.3%
Customer Service	82.1%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

NHP: Strengths

The following measures' FY 2021–2022 scores for NHP were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

The following measures' FY 2021–2022 scores for NHP were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

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

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

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

The following measures' FY 2021–2022 scores for NHP were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

The following measures' FY 2021–2022 scores for NHP were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of All Health Care*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends NHP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

NHP: Child CAHPS

Table 3-22 shows the child CAHPS results for NHP for FY 2021–2022.

Table 3-22—FY 2021–2022 Child CAHPS Top-Box Scores for NHP

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	69.3%	70.8%
Rating of All Health Care	64.4%+ ↓	65.1% ↓
Rating of Personal Doctor	78.3%	76.1%
Rating of Specialist Seen Most Often	64.0%+	70.9%
Getting Needed Care	75.3%+ ↓	80.2% ↓
Getting Care Quickly	81.5%+	84.9%
How Well Doctors Communicate	95.7%+	93.6%
Customer Service	82.4%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

NHP: Strengths

The following measures' FY 2021–2022 scores for NHP were higher, although not statistically significantly, than the 2021 NCQA national averages and statewide average scores for FY 2021–2022:

- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

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

The following measures' FY 2021–2022 scores for NHP were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*

The following measures' FY 2021–2022 scores for NHP were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends NHP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Quality Improvement Plan

Table 3-23 presents NHP's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-23—Summary of NHP QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Psychotherapy	Procedure Code	79.6%	0%	90%	70%
	Diagnosis Code	82.5%	100%	100%	100%
	Place of Service	75.2%	100%	100%	100%
	Service Category Modifier	79.6%	100%	100%	100%
	Units	81.8%	100%	100%	100%
	Service Start Date	82.5%	100%	100%	100%
	Service End Date	82.5%	100%	100%	100%
	Population	82.5%	100%	100%	100%
	Duration	82.5%	100%	100%	100%
	Staff Requirement	82.5%	100%	100%	100%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

NHP: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- NHP achieved 100 percent accuracy for nine out of 10 encounter data types in the psychotherapy claim type.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- The *procedure code* encounter data type dropped to 0 percent accuracy in month one, due to the audited charts not meeting minimum documentation requirements. In month two, *procedure code* increased to 90 percent, then declined to 70 percent in month three due to incorrect use of psychotherapy when targeted case management was more appropriate.
- NHP reported that the inaccuracies in baseline scores were due to charts lacking information on therapeutic interventionists and having insufficient treatment plans to follow.

To address these opportunities for improvement, HSAG recommends NHP:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-24 displays the MHP Audit compliance scores for NHP for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-24—FY 2021–2022 MHP Audit Score for NHP

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
NHP	2	98%	Inpatient	100%	98%~
			Outpatient	94%	

~ *Indicates that the score remained unchanged as compared to the previous review year.*

NHP: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- NHP demonstrated consistent performance compared to the previous review year and scored 100 percent compliance for all inpatient records reviewed.
- NHP delegated UM activities to Beacon and followed policies and procedures regarding adequate monitoring and oversight of the delegated UM activities.
- NHP demonstrated that Beacon used nationally recognized UR criteria, including InterQual UR criteria, for all MH determinations and outpatient SUD determinations, and ASAM level of care criteria for inpatient and residential SUD determinations.
- NHP followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually, including requiring an 80 percent passing score.
- NHP followed policies and procedures related to which services require prior authorization and provided notices to the member and provider in all cases reviewed.
- NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all the required information.
- In all cases involving a medical necessity review, NHP offered requesting providers peer-to-peer reviews prior to finalizing a denial determination.
- During the MHP interview, NHP reported several best practices related to implementation of the new SUD inpatient and residential benefit package starting in 2021, including monthly and quarterly provider forums, individualized training for providers as needed, provider newsletter content that includes new codes or changes to coding requirements, no longer declining to accept provider applications based on network sufficiency in a particular area, and utilization of the state-developed uniform service request form for SUD services.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- UR criteria used for the denial determinations were not properly documented in two outpatient files.
- NABD templates were minimally compliant regarding the reason and rationale to the member.

- During the MHP interview, Beacon staff members reported that referral to care coordination is not typically made after a denial determination and the care coordination department is not copied on or notified of the denial.

To address these opportunities for improvement, HSAG recommends NHP:

- Enhance monitoring mechanisms to ensure UR criteria used for denial determinations are properly documented.
- Add additional information to the reason and rationale for the denial so that members may better understand the circumstances surrounding the denial of services.
- Collaborate with Beacon to develop a process for making care coordination referrals when needed to ensure appropriate services are arranged when services needed differ from services requested and denied.

Quality of Care Concern Audit

NHP used an internally developed definition for QOC issues. NHP submitted a national *Member Safety Program Policy and Procedure* for review. The definition was stated in policy. NHP had a total of four substantiated cases reported during the review period and used a five-level rating system to define the severity of QOC issues. NHP's national *Member Safety Program Policy and Procedure* stated the definitions for each severity level. Professionals with varying qualifications and/or degrees reviewed QOC issues submitted to NHP.

The following trends were identified within the sample cases reviewed:

- Three out of four sample cases had a severity level of minimal and one case was moderate.
- All four case outcomes resulted in a CAP for the provider/facility.
- Two of the four sample cases were related to poor or lack of documentation, one case was related to failure to coordinate care, and the case with the highest severity level was a case that had an attempted suicide.
- NHP staff members stated that the member's race, ethnicity, or disability status are not collected on the form as part of the QOC review; therefore, NHP did not provide this information for sample cases reviewed for the audit.
- NHP had a system for identifying and addressing all alleged QOC issues. When a concern was raised, NHP investigated, analyzed, tracked, trended, and resolved QOC issues according to policy. NHP adhered to a national policy titled *Member Safety Program Policy and Procedure* and a Colorado-specific policy addendum titled *Member Safety Program—Serious Reportable Event, QOC Issues, and Outlier Practice Patterns*. Based on review of four sample cases and associated documents, HSAG determined that NHP adhered to its internal policies and procedures.

- None of the four sample cases reviewed had outcomes reported to a regulatory agency. NHP's Colorado-specific policy provided a process for reporting to any regulatory agency, which stated that for cases where the QOC issue is substantiated and the occurrence is clearly outside of accepted standards of practice, the quality management (QM) specialist conducting the investigation will request the quality-of-care committee (QOC Committee) to make a recommendation for reporting the occurrence to the state licensing board or appropriate regulatory agency. If the QOCC recommends reporting a provider to the state licensing board/regulatory agency, the provider relations (PR) director will take that recommendation to the Credentialing Committee for review; if the committee concurs with the recommendation, the PR director will submit the recommendation to the national Credentialing Committee for further action. In cases where the provider is not in the network (e.g., single case agreement or recent network resignation), the QM specialist will prepare a report to the state licensing board/regulatory agency and submit to Beacon's legal department for approval prior to sending the report.

NHP: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for NHP:

- The *Health First Colorado Member Handbook* and information on the MCE's website included information for the member about the process for reporting a grievance. For the members' ease of understanding, the member materials did not distinguish the difference between a grievance and a QOCG.
- The *Colorado Medicaid Provider Handbook* provided examples of QOC issues and reminded providers that they are required to respond to inquiries, assist with investigations, provide CAPs when requested, and report progress toward addressing concerns through corrective actions as requested. A link to an Adverse Incident/Quality of Care Report form was available on the MCE's website.
- NHP's national *Member Safety Program Policy and Procedure* stated that investigations are expected to be completed within 60 calendar days from the date reported to NHP. Some milestone dates were also identified. For example, if the QOC issue is potentially urgent, the investigation must be initiated within one to two business days of receipt. Also, QOC issues assigned a risk rating of two or moderate risk have an investigation of the occurrence initiated within 14 calendar days of receipt, while those assigned an initial rating of one or low risk have an investigation initiated within 30 calendar days of receipt. NHP's QualityConnect system tracks the timing and alerts staff when the 60-calendar-day mark is approaching.
- For all four sample cases reviewed, NHP required the provider/facility to implement a CAP. QM staff members monitor CAP status and the effectiveness of the CAP to ensure the facility/provider do not have any further substantiated QOC issues of the same type for the current calendar year.
- As needed, and according to policy, NHP reviewed QOC issues with the following:
  - Professional (peer) review committee

  - NHP's legal department
  - Credentialing Committee
  - Beacon's Executive Medical Management Committee

- NHP reported that it began reporting all closed cases to the Department in October 2021. For this reporting, QM staff members prepared a QOC Process Spreadsheet, which was sent to the Department quarterly.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

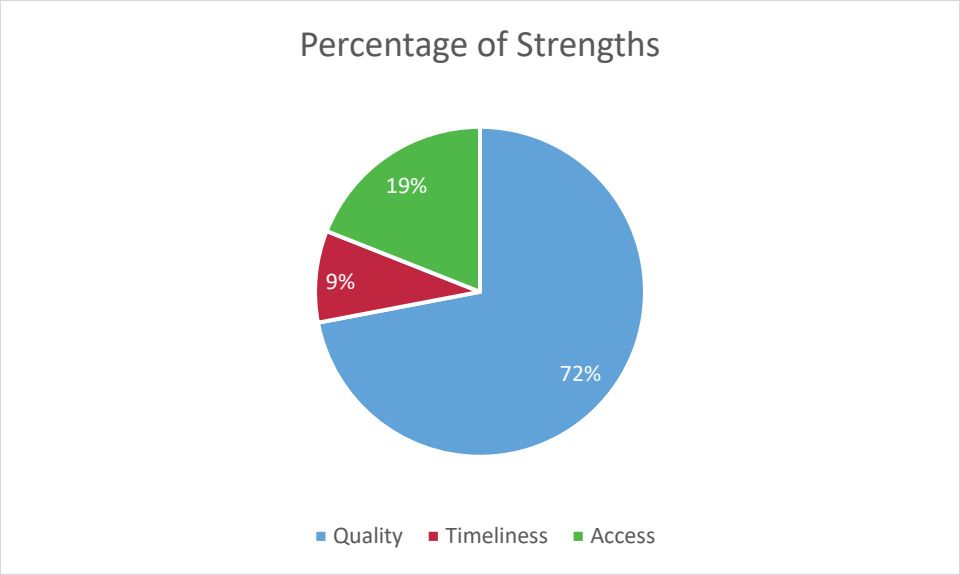
- NHP developed a Potential Quality Issue (PQI) form. The PQI form documented points based on the severity level of the QOC issue. The form also provided a sum or points accrued in the last 24 months for the particular provider/facility. Once a threshold of seven points in a 24-month period has been reached, a referral will be made by the QOCC to the Credentialing Committee. If the Credentialing Committee concurs with the recommendation, the PR director will submit the recommendation to the national Credentialing Committee for further action. This process was recently implemented and therefore all sample cases reviewed did not include the PQI form. Additionally, this process was not described in policies and procedures submitted for review.
- NHP staff members stated that QOC issue training was last held in January 2021. However, all new staff members receive the training during their onboarding process.

To address these opportunities for improvement, HSAG recommends NHP:

- Implement ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Include the PQI form and point system process.
  - Include a process for sending acknowledgment and resolution letters to any party reporting the QOC issue.
  - Add severity levels and definitions.
  - Include information about the goal for completing QOC investigations.
- Continue notifying the Department of QOC issues received. Additionally, NHP should reach out to the Department to report ad hoc cases with severity, systematic concerns, and termination of any network provider.
- Continue to work in tandem with the grievance coordinator/Office of Member and Family Affairs (OMFA).
- Consider integrating member information such as race, ethnicity, and disability status into the QOC database or merging with available demographic data to monitor for issues or trends.

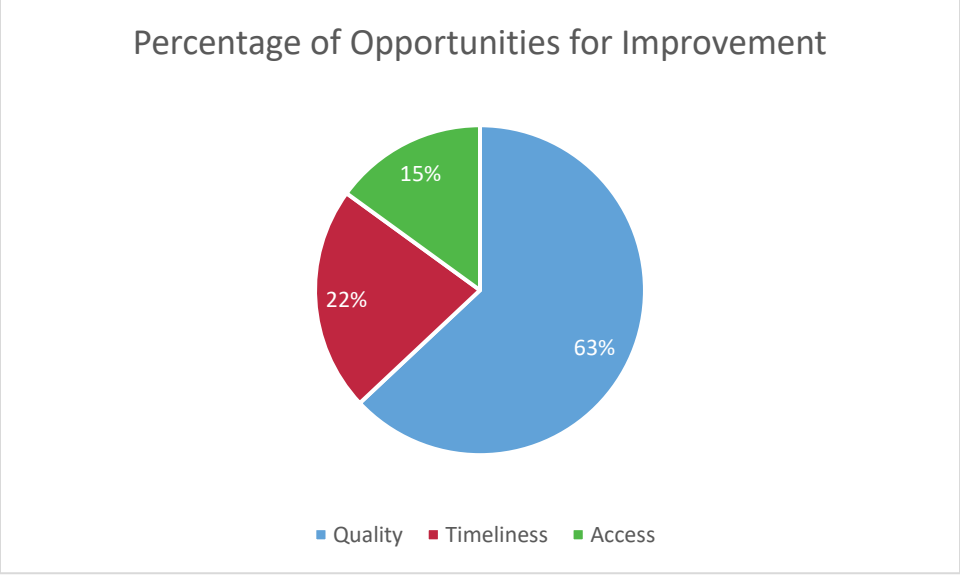
Region 3—Colorado Access

Figure 3-5—Percentage of Strengths by Care Domain for COA Region 3*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-6—Percentage of Opportunities for Improvement by Care Domain for COA Region 3*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are COA Region 3's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, COA Region 3 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, COA Region 3 established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-25 and Table 3-26 summarize COA Region 3's PIP activities that were completed and validated in FY 2020–2021. Table 3-25 provides the SMART Aim statements that COA Region 3 defined for the two PIP outcome measures in Module 1.

Table 3-25—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for COA Region 3

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%.

Table 3-26 summarizes the preliminary key drivers and potential interventions COA Region 3 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-26—Preliminary Key Drivers and Potential Interventions 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. • 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 BH referral process. • Provider education on appropriate BH follow-up coding practices. • Internal and external provider availability for BH 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 BH and referral resources.

FY 2021–2022 PIP Activities

In FY 2021–2022, COA Region 3 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, COA Region 3 developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, COA Region 3 submitted testing plans for three interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as COA Region 3 carried out PDSA cycles to evaluate intervention

effectiveness. Table 3-27 presents the FY 2021–2022 Module 3 validation findings for COA Region 3's three interventions.

Table 3-27—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Peak Vista EHR optimization and coding changes: standardize depression screen scoring (positive and negative), adapt EHR to support ordering and coding of depression screening and follow-up services, provider education and best practices toolkit for depression screening and follow-up services and workflows	• Missed depressive symptoms • Lack of standardized depression screening instrument • Lack of provider awareness of appropriate codes • Providers unaware of unmet needs • EHR errors	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Standards of care: provider education, follow-up coding, and training • Financial stability and billing accuracy	• Percentage of members documented as "Watchful waiting; reassess at next visit" with a corresponding G8510 CPT code • Percentage of members documented as "Patients without a follow-up" with a corresponding G8510 CPT code • Percentage of members not documented as "PHQ-9 Declined," or "Medically Excluded from PHQ-9" with a corresponding depression screening code (G8510 or G8431) • Percentage of members documented as "PHQ-9 Declined" • Percentage of members documented as "Medically Excluded from PHQ-9" • Percentage of claims with a depression screening result code (G8510 or G8431) that were coded G8510
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of EHR to support for protocol and coding standardization, using	• Providers not aware of appropriate specification codes for the follow-up visit	• Financial stability and billing accuracy • Standards of care: provider education, follow-up coding, and training.	• Percentage of well visits with a positive depression screening result, indicated by code G8431, with a follow-up service within 30 days, indicated by code H0002

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
automation where possible			
A two-pronged approach to expanding BH services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the VCCI program for follow-up BH services via telehealth	• Follow-up visit is not occurring within 30 days of positive screen • Member is not reached for follow-up BH services • BH needs are not communicated to BH provider	• Standards of care: efficient referral processes • Internal and external BH provider availability • Financial stability and billing accuracy • Member access, knowledge, and engagement	• Percentage of available hiring and retention bonuses received by future and/or current BH staff (multiple measures) • Percentage of consults and therapy/assessments conducted via telehealth through the VCCI program (multiple measures)

In Module 3, COA Region 3 selected three interventions to test for the PIP. The interventions addressed process failures in clinic workflows, coding practices, and BH provider availability. For each intervention, COA Region 3 defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, COA Region 3 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- Selected three interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of three interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

- HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. COA Region 3 addressed all Module 3 PIP validation criteria.

To support successful progression of COA Region 3's PIP in the next fiscal year, HSAG recommends:

- COA Region 3 collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- COA Region 3 ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, COA Region 3 should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, COA Region 3 should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-28 shows the performance measure results for COA Region 3 for MY 2019 through MY 2021.

Table 3-28—Performance Measure Results for COA Region 3

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	47.75%	38.84%	45.09%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.76%	64.71%	56.76%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	27.83%	31.97%	30.50%	48.22%
Follow-Up After a Positive Depression Screen	43.51%	41.50%	43.47%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	12.05%	12.17%	15.41%	30.56%

COA Region 3: Strengths

The following performance measure rates for MY 2021 increased from the previous year for COA Region 3:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 3 Overall Evaluation

Table 3-29 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2021–2022.

Table 3-29—Summary of COA Region 3 Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	18	17	1	0	0	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**40**	**1**	**0**	**0**	**98%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-30—Compliance With Regulations—Trended Performance for COA Region 3

Standard and Applicable Review Years*	COA Region 3 Average—Previous Review	COA Region 3 Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	80%	
Standard II—Access and Availability (2019–2020)	100%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**100%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**94%**	**94%**

Standard and Applicable Review Years*	COA Region 3 Average—Previous Review	COA Region 3 Average—Most Recent Review**
Standard VI—Grievance and Appeal Systems (2019–2020)	80%	
Standard VII—Provider Selection and Program Integrity (2020–2021)	100%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	100%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**88%**	**100%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, each of the standards reviewed for COA Region 3 demonstrated high-achieving or improved scores from the previous review year, indicating a strong understanding of most federal and State regulations.

COA Region 3: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- COA Region 3's care coordination teams consisted of multi-disciplinary staff members and were organized by PH, BH, and resource and referral teams, which were tailored to the target population, such as members in foster care. These teams included mostly professionally licensed staff, such as BH professionals and registered nurses (RNs).
- COA Region 3's website and provider manual offered information on diversity and cultural training programs that foster respect and appreciation of differences in perspectives, beliefs, backgrounds, race, and sexual orientation. Additionally, the training program available to COA staff members and providers included details to promote culturally sensitive services.
- COA Region 3 had robust processes to ensure that specific documents available electronically on the COA Region 3 website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines.

- COA Region 3 submitted detailed documents that demonstrated adherence with a multi-stream outreach approach to engage and inform pregnant members and members ages 20 and under about EPSDT benefits.

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

HSAG found the following opportunities for improvement:

- COA Region 3 did not send any follow-up information after the care coordination outreach call detailing information provided over the phone to the member.
- COA Region 3's policy to submit an Americans with Disabilities Act (ADA) complaint and receive a resolution did not clearly outline information regarding that COA Region 3 must resolve the grievance within the state-required time frames and staff members may assist the member in submitting a complaint with the Office of Civil Rights.
- The *New Member Booklet* contained some but not all required information. COA Region 3 did not inform members that auxiliary aids provided would be at no cost to the member or that critical materials can be printed and mailed within five business days.
- COA Region 3's policies and procedures did not have current federal language regarding the timeline to notify members of a provider termination, which was updated in December 2020 to include "or 30 days prior to the effective date of termination."

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Consider sending a follow-up letter to the member detailing the information provided during the care coordination outreach call should the member want to reach out to their care coordinator.
- Update the applicable policy to clarify that if a member submits a complaint with COA Region 3, COA Region 3 must resolve the grievance within the state-required time frames. HSAG also recommends COA Region 3 clarify that staff members may assist the member in submitting a complaint with the Office of Civil Rights and that the timelines and appeal procedures listed in the policy are consistent.
- Include full details regarding auxiliary aids in COA Region 3's *New Member Booklet* and inform members of their right to receive documents in paper format within five business days on websites where critical member materials are posted.
- Update the applicable policies and procedures to include the language "or 30 days prior to the effective date of the termination" when notifying the member of a provider termination.

Validation of Network Adequacy

COA Region 3: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- While COA Region 3 did not meet all minimum time and distance network requirements across all counties in each county designation, General BH Practitioners and Pediatric Primary Practitioners (MD, DO, NP, CNS) had two counties that did not meet the standards, but they were only 1 percent from meeting the standard. 

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

HSAG found the following opportunities for improvement:

- COA Region 3 did not meet the minimum time and distance network requirements for all SUD ASAM levels, Psychiatric Hospitals, Gynecology OB/GYN (MD, DO, NP, CNS), and Gynecology OB/GYN (PA) across multiple contracted counties. 

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-31 presents COA Region 3's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-31—FY 2021–2022 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	74.5%	92.7%
Principal Surgical Procedure Code	97.1%	NA	NA
Diagnosis Code	83.9%	78.1%	97.1%
Place of Service	NA	77.4%	100%
Service Category Modifier	NA	74.5%	92.7%
Units	NA	87.6%	100%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Revenue Code	93.4%	NA	NA
Discharge Status	94.2%	NA	NA
Service Start Date	90.5%	87.6%	100%
Service End Date	95.6%	87.6%	100%
Population	NA	87.6%	100%
Duration	NA	81.0%	100%
Staff Requirement	NA	82.5%	100%

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

Table 3-32 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 3-32—FY 2021–2022 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	100.0%	90.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	90.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	100.0%	90.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	90.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	100.0%	100.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	90.0%	100.0%
Staff Requirement	NA	90.0%	100.0%

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

COA Region 3: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- 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 four of the six inpatient services data elements, eight of the 10 psychotherapy services data elements, and eight of the 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- COA Region 3's self-reported EDV results demonstrated only a moderate level of accuracy within the psychotherapy services category, including 74.5 percent accuracy for the *procedure code* and *service category modifier* data elements.

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

COA Region 3: Adult CAHPS

Table 3-33 shows the adult CAHPS results for COA Region 3 for FY 2021–2022.

Table 3-33—FY 2021–2022 Adult CAHPS Top-Box Scores for COA Region 3

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	54.5%	55.2% ↓
Rating of All Health Care	59.1%+	56.5%
Rating of Personal Doctor	61.2%	66.2%
Rating of Specialist Seen Most Often	67.8%+	69.2%
Getting Needed Care	77.7%+	80.9%
Getting Care Quickly	77.3%+	78.9%

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
How Well Doctors Communicate	88.8%+	91.3%
Customer Service	82.5%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

COA Region 3: Strengths

The following measure's FY 2021–2022 score for COA Region 3 was higher, although not statistically significantly, than the 2021 NCQA national average and statewide average score for FY 2021–2022:

- *Rating of All Health Care*

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

The following measures' FY 2021–2022 scores for COA Region 3 were lower, although not statistically significantly, than the 2021 NCQA national averages and statewide average scores for FY 2021–2022:

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

To address these low CAHPS scores, HSAG recommends COA Region 3:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.

- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including:
  - Enhancing provider informational materials and exploring providers' ability to communicate effectively with members.
  - Communications programs for providers or care reminders to encourage timely requests for services by the members.
- Assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

COA Region 3: Child CAHPS

Table 3-34 shows the child CAHPS results for COA Region 3 for FY 2021–2022.

Table 3-34—FY 2021–2022 Child CAHPS Top-Box Scores for COA Region 3

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	73.3%	70.8%
Rating of All Health Care	64.1% ↓	65.1% ↓
Rating of Personal Doctor	71.4% ↓	76.1%
Rating of Specialist Seen Most Often	71.8%+	70.9%
Getting Needed Care	82.6%+	80.2% ↓
Getting Care Quickly	86.5%+	84.9%
How Well Doctors Communicate	91.9%	93.6%
Customer Service	88.7%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

COA Region 3: Strengths

The following measures' FY 2021–2022 scores for COA Region 3 were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Customer Service*

The following measures' FY 2021–2022 scores for COA Region 3 were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

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

The following measures' FY 2021–2022 scores for COA Region 3 were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

The following measures' FY 2021–2022 scores for COA Region 3 were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

To address these low CAHPS scores, HSAG recommends COA Region 3:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.

- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including enhancing provider informational materials and exploring providers' ability to communicate effectively with members.

Quality Improvement Plan

Table 3-35 presents COA Region 3's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-35—Summary of COA Region 3 QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Inpatient	Diagnosis Code	89.1%	100%	100%	NA^
Psychotherapy	Procedure Code	53.2%	100%	100%	100%
	Diagnosis Code	85.4%	100%	100%	100%
	Place of Service	75.9%	100%	50%	50%
	Service Category Modifier	53.2%	100%	100%	100%
	Duration	85.4%	100%	100%	100%
Residential Services	Procedure Code	75.9%	100%	100%	100%
	Place of Service	82.5%	100%	100%	100%
	Service Category Modifier	75.9%	100%	100%	100%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*
^ NA = not applicable. COA Region 3's inpatient pilot partner was closed during January 2022 due to the Marshall Fire in Colorado; therefore, only claims from November 2021 and December 2021 were included in this QUIP.

COA Region 3 reported that the inpatient pilot partner was closed in January 2022 due to the Marshall Fire incident in Colorado. As a result, COA Region 3 included only claims from November and December 2021 in this QUIP. The Marshall Fire incident had an impact on the inpatient month three data for the *diagnosis code* encounter data type, as shown in the table.

COA Region 3: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- Nearly all encounter data types across claim types improved to 100 percent accuracy in month two and maintained 100 percent accuracy for month three.
- COA Region 3 used an effective multi-intervention approach such as monitoring CAPs and provider training on technical and shift note documentation requirements.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- For the psychotherapy *place of service* encounter data type, COA Region 3 reported that the reason for errors was due to confusion amongst providers regarding when to code a service to telehealth.

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-36 displays the MHP Audit compliance scores for COA Region 3 for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-36—FY 2021–2022 MHP Audit Score for COA Region 3

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
COA Region 3	3	100%	Inpatient	100%	100%~
			Outpatient	100%	

~ *Indicates that the score remained unchanged as compared to the previous review year.*

COA Region 3: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- COA Region 3 demonstrated consistent performance compared to the previous review year and scored 100 percent compliance for all inpatient and outpatient denial records reviewed.
- COA Region 3 consistently used nationally recognized UR criteria, including InterQual UR criteria, for all MH determinations and ASAM level of care criteria for all SUD determinations.
- COA Region 3 followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually including requiring a 90 percent passing score. Additionally, COA Region 3 followed policies and procedures related to which services require prior authorization and providing notices to the member and the provider.
- All NABDs were written at a reading level that was easy to understand and provided on a Department-approved template that contained all required information.
- COA Region 3 offered requesting providers peer-to-peer reviews prior to finalizing a denial determinations for all cases involving a medical necessity review.
- COA Region 3 used several best practices to implement the new SUD benefits.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- COA Region 3 did not include the specific name of the criteria (InterQual, ASAM, etc.) used within the NABD.

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Include in the NABD the specific name of the criteria used to make the denial determination.

Quality of Care Concern Audit

COA Region 3 used an internally developed definition for QOCCs. COA Region 3 submitted a *Quality-of-Care Concern* desk procedure along with a *Quality-of-Care Concern Investigation Policy and Procedure*. The definition mentioned above is stated in the desk procedure. The definition stated in policy is similar. COA Region 3 had a total of 34 substantiated cases reported during the review period and used a four-level rating system to define the severity of QOCCs. COA Region 3's policy did not define the severity levels; however, COA Region 3's *Quality-of-Care Concern* desk procedure defined

each severity level. Professionals with varying qualifications and/or degrees reviewed QOCCs submitted to COA Region 3.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, five members were White and five were Hispanic or Latino.
- Three out of 10 members were disabled.
- Of the 10 sample cases, five were a severity level one and five were a severity level two.
- Four out of 10 cases were related to lack of follow-up/discharge planning.
- Two out of 10 case outcomes resulted in a CAP required by COA Region 3.

COA Region 3 had a system for identifying and addressing all alleged QOC concerns. When a concern was raised, COA Region 3 investigated, analyzed, tracked, trended, and resolved QOC concerns according to policy. COA Region 3 adhered to a COA Region 3 policy titled *Quality-of-Care Concern Investigation Policy and Procedure*. In addition to the policy, the RAE adhered to a *Quality-of-Care Concern* desk procedure, which provided direction for handling and reviewing QOC concerns. Based on review of 10 sample cases and associated documents, HSAG determined that COA Region 3 adhered to its internal policies and procedures.

None of the 10 sample cases reviewed had outcomes reported to a regulatory agency or licensing board. COA Region 3's policy stated that the QM department will report to the chief compliance officer any issues that may need to be reported to an appropriate regulatory agency or state licensing board and child or adult protective services for further research, review, or action.

COA Region 3: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 3:

- COA Region 3's QM department investigated and resolved concerns directly related to the quality of the medical care or BH care of a member. Policies described a process whereby the QM department, with oversight by a medical director or physician designee, would investigate, analyze, track, trend, and resolve QOCCs.
- The *Health First Colorado Member Handbook* and information on the RAE's website included information for the member about the process for reporting a grievance. Members were instructed to speak with their provider, the RAE, and/or Ombudsman. The member materials did not distinguish the difference between a grievance and a QOCG.
- If a grievance was clinical care-based and believed to meet the qualifications of a potential QOCC, the grievance team would send the grievance to the QM department to confirm the concern meets

the threshold of a QOCC. The grievance could also be split between the QM department and grievance department if only parts of the complaint meet the threshold of a QOCC.

- The provider manual included definitions of a QOCC and critical incident. The manual also included information for reporting potential QOCCs and critical incidents and that reporting a potential concern or incident is confidential. COA Region 3 provided evidence of a provider newsletter that was sent via email to all providers on December 9, 2021. The newsletter provided information about a new form that should be utilized for reporting concerns and/or incidents. The *Quality of Care and Critical Incident Notification* form was linked on COA Region 3's website and could be emailed to the QOC email inbox at COA Region 3.
- COA Region 3 had letter and form templates that were clear and concise. Additionally, if a CAP needed to be developed, a helpful tips guide for developing a CAP was given to the provider/facility, along with a CAP template. Acknowledgment and resolution notification were sent to the individual who reported/initiated, which may or may not be internal COA Region 3 staff.
- Throughout the sample case review and interview discussion, COA Region 3 demonstrated a collaborative approach with facilities and/or providers if an intervention or CAP was needed. COA Region 3 provided an education letter and/or conducted one-on-one meetings with providers to guide them through the CAP process. COA Region 3 staff members stated they would continue to monitor the facility/provider to ensure the QOCC volume decreases as a means of monitoring the effectiveness of the intervention or CAP.
- As needed, and according to policy, COA Region 3 reviewed QOCCs with the following:
  - External professional review (peer review)
  - Compliance department
  - COA Region 3's legal department
  - Credentialing Committee
- COA Region 3 staff members stated that care managers and UM coordinators participate in a QOCC training. Additionally, COA Region 3 staff members reported that an increase in volume of QOCCs was noted after the training; however, this increase was expected.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

- COA Region 3 staff members reported that the QM team and grievance team work in tandem if the QOCC is reported by a member/member advocate. However, possible gaps could exist if the QM team investigates the QOCC but the grievance team sends the acknowledgment and resolution

letters. For the QOCC tracking, the QM team did not capture dates or other evidence that these letters were sent by the grievance team.

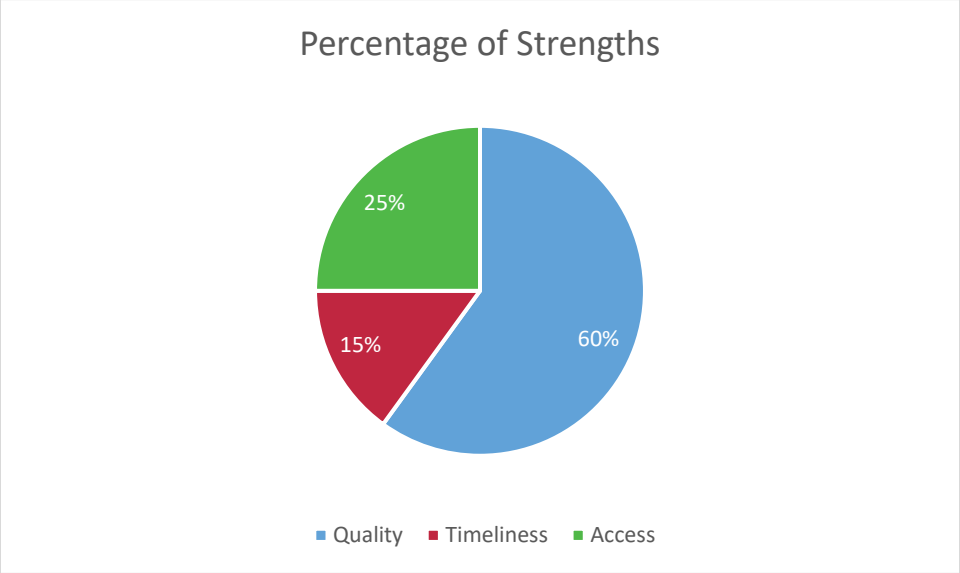
- At the time of this audit, COA Region 3 did not have timelines or time frames for the QOCC process outlined in policy. During the interview, staff members indicated that the RAE's goal is for 90 percent of QOCCs to be closed in 90 days.
- COA Region 3's policy included information for monitoring trends that emerge from QOCC notifications. Staff members reported that the QM department trends information on an ongoing basis and reports the occurrence of QOCCs annually in the quality report, which is ultimately reported to the Department. Additionally, COA Region 3 reported to the Department if the Department requested or if a severe or systemic concern was identified. One sample case reviewed had been referred to COA Region 3 by the Department. The QOCC was investigated by COA Region 3 and reported to the Department according to contractual requirements.
- COA Region 3 staff members stated they would like for the Department to guide the RAEs through the required QOCC process, especially with the notification and reporting requirements.

To address these opportunities for improvement, HSAG recommends COA Region 3:

- Continue ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Incorporate contract requirements.
  - Include a process for reporting to the Department.
  - Include information about the goal for completing QOC investigations.
- Have its QM department continue to work in tandem with the grievance department to send out acknowledgment and resolution letters to members/member advocates. Additionally, COA Region 3 could implement a process for QOCC tracking to capture dates or other evidence that these letters were sent by the grievance team.
- Develop a more regular reporting process to notify the Department of QOCCs received, according to contractual requirements. Currently, COA Region 3 is reporting this information to the Department annually.

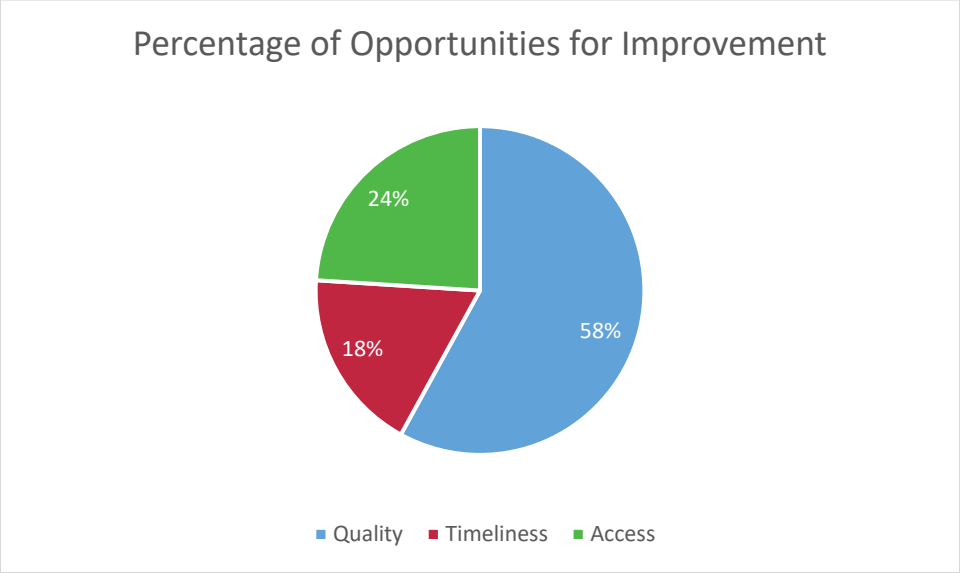
Region 4—Health Colorado, Inc.

Figure 3-7—Percentage of Strengths by Care Domain for HCI*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-8—Percentage of Opportunities for Improvement by Care Domain for HCI*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are HCI's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, HCI continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, HCI established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-37 and Table 3-38 summarize HCI's PIP activities that were completed and validated in FY 2020–2021. Table 3-37 provides the SMART Aim statements that HCI defined for the two PIP outcome measures in Module 1.

Table 3-37—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for HCI

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 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 June 30, 2022, use key driver diagram interventions to increase the percentage of BH 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%.

Table 3-38 summarizes the preliminary key drivers and potential interventions HCI identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-38—Preliminary Key Drivers and Potential Interventions 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.
Potential Interventions	• Identify provider billing and reporting strategies to support depression screening documentation in EMR. • Implement provider town halls 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 BH 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 BH follow-up services on well visit claim when follow-up services are provided on the same day as the positive depression screen.

FY 2021–2022 PIP Activities

In FY 2021–2022, HCI continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, HCI developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, HCI submitted testing plans for three interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as HCI carried out PDSA cycles to evaluate intervention effectiveness. Table 3-39 presents the FY 2021–2022 Module 3 validation findings for HCI's three interventions.

Table 3-39—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Staff feedback on depression screening performance and training on depression screening procedures	MA skips PHQ-4[1] during check-in process without medical rationale	MA training/awareness of depression screening impact	• Percentage of outpatient visits for eligible members within Valley-Wide Health Systems during which a depression screening was conducted (claims-based) • Percentage of outpatient encounters for eligible members within Valley-Wide Health Systems during which a depression screening was conducted (EHR-based)
Establish a clinical policy for BH referral after a positive depression screen and provide staff training on BH referral policy and procedures following a positive depression screen	Provider addresses positive depression screen with a follow-up plan and/or psychopharmacology without BH provider involvement	Timely communication with BH providers following positive depression screen	• Percentage of members with a positive depression screen at Valley-Wide Clinic who have a follow-up BH service within 30 days of the positive screen (claims-based) • Percentage of members with a positive depression screening at Valley-Wide Clinic who have a BH encounter following the positive depression screen
Provide training to coding auditors on the correct criteria for entering G-codes for positive and negative depression screening results in the EHR	Incorrect code used for screening	Data accuracy	• Percentage of encounters reviewed across all Valley-Wide clinics with an appropriate depression screening G-code documented in the EHR

[1]*PHQ = Patient Health Questionnaire*

In Module 3, HCI selected three interventions to test for the PIP. The interventions addressed process gaps or failures in staff training and clinical policies and procedures for depression screening and follow-up services, and coding practices. For each intervention, HCI defined one or more intervention

effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, HCI continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for HCI:

- Selected three interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of three interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. HCI addressed all Module 3 PIP validation criteria.

To support successful progression of HCI's PIP in the next fiscal year, HSAG recommends:

- HCI collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- HCI ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, HCI should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, HCI should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-40 shows the performance measure results for HCI for MY 2019 through MY 2021.

Table 3-40—Performance Measure Results for HCI

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	47.93%	31.19%	48.51%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	74.36%	71.20%	70.43%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	46.03%	37.58%	36.49%	48.22%
Follow-Up After a Positive Depression Screen	42.98%	34.64%	50.19%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	24.93%	23.70%	33.11%	30.56%

HCI: Strengths

The following performance measure rates for MY 2021 increased from the previous year for HCI:

- *Engagement in Outpatient SUD Treatment* 
- *Follow-Up After a Positive Depression Screen* 
- *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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment* 
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* 
- *Follow-Up Within 7 Days of an ED Visit for SUD* 
- *Follow-Up After a Positive Depression Screen* 
- *Behavioral Health Screening or Assessment for Children in the Foster Care System* 

To address these opportunities for improvement, HSAG recommends HCI:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

HCI Overall Evaluation

Table 3-41 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 2021–2022.

Table 3-41—Summary of HCI Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	14	12	2	0	4	86%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**37**	**34**	**3**	**0**	**4**	**92%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-42—Compliance With Regulations—Trended Performance for HCI

Standard and Applicable Review Years*	HCI Average—Previous Review	HCI Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	97%	
Standard II—Access and Availability (2019–2020)	94%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**82%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**100%**	**86%**
Standard VI—Grievance and Appeal Systems (2019–2020)	83%	
Standard VII—Provider Selection and Program Integrity (2020–2021)	94%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	94%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**88%**	**86%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, HCI demonstrated consistent high-achieving or improved scores for Standard III—Coordination and Continuity of Care and Standard IV—Member Rights, Protections, and Confidentiality compared to the previous review year. However, Standard V—Member Information Requirements and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services both showed a decline in scores compared to the previous review year.

HCI: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for HCI:

- HCI members were able to enter care coordination in various ways such as through the call center by speaking to a customer service agent, referrals from community agencies and other RAEs, PCMPs informing members of care coordination services available to them, identifying care coordination needs through the complaints/grievance department, the daily ADT feed, data workflow through Department-identified members with complex and chronic conditions needing care coordination services, and the Health Needs Survey.

- HCI had a policy that described procedures and guidelines for employees, contractors, and network providers for the uses and disclosures of PHI. Additionally, staff members discussed that annual trainings are provided to employees and additional trainings are provided to specific departments that deal with more sensitive information to ensure that only the minimal amount of information is accessed by these employees. 
- HCI organized educational forums and a texting campaign designed to help members understand the requirements and benefits of the plan. Text message scripts included different information, such as member handbook information, website link information, well-child visit reminders, the nurse advice line numbers, member rights, advance directives, vaccinations, BH, crisis services, and how to get an insurance card. 
- HCI and Beacon (HCI's ASO) staff members attended local formal and informal meetings, such as county Department of Health Services and CDAC meetings, to increase awareness about EPSDT. 

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

HSAG found the following opportunities for improvement:

- HCI's policies, procedures, and delegate agreements did not clearly illustrate the roles, responsibilities, and monitoring in place for all those involved in HCI's multi-tiered care coordination delegation model. 
- Some member-specific websites contained contrast error issues related to accessibility issues and Section 508 compliance, critical member materials did not include all the required components of a tagline, and HCI did not consistently inform members that information provided electronically to members is available in paper form "within five business days" on its websites. HCI's documents did not include information about its website to meet all required member information components. 
- Although HCI's quarterly outreach reports indicated a low success rate for completions, HCI did not include voicemails in this overall count. Additionally, the EPSDT Tip Sheet did not follow American Academy of Pediatrics *Bright Futures Guidelines* time frames for recommended teen well visits. HCI did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period, and annual outreach solely relied on text message outreach to members. 

To address these opportunities for improvement, HSAG recommends HCI:

- Expand the language in the applicable policies, procedures, and delegate agreements to better illustrate the roles, responsibilities, and monitoring in place for all those involved in HCI's multi-tiered care coordination delegation model.

- Expand procedures and reporting mechanisms to address, prioritize, and rectify contrast issues relating to accessibility and Section 508 compliance; revise critical member materials to include all required components of a tagline; and develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days. HSAG also recommends HCI conduct ongoing communication with the Department to ensure the updated welcome letter includes all required components such as HCI's website address.
- Verify the definition of "completed" outreach with the Department and further explore the addition of voicemails in upcoming quarterly outreach reports, update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* time frame for annual well visits, and enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.

Validation of Network Adequacy

HCI: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for HCI:

- While HCI did not meet all minimum time and distance network requirements across all counties in each county designation, Adult, Family and Pediatric Primary Care Practitioners (MD, DO, CNS), General BH Practitioners, and Pediatric BH Practitioners only had one county in which they did not meet the standards and were less than 1 percent from meeting the standard. 

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

HSAG found the following opportunities for improvement:

- HCI did not meet the minimum time and distance network requirements for Gynecology OB/GYN (MD, DO, NP, CNS), Gynecology OB/GYN (PA), SUD treatment facilities and Psychiatric Hospitals across multiple contracted counties. 

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends HCI:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-43 presents HCI's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-43—FY 2021–2022 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	98.5%	97.8%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	95.6%	95.6%	97.1%
Place of Service	NA	84.7%	97.8%
Service Category Modifier	NA	99.3%	97.8%
Units	NA	99.3%	97.1%
Revenue Code	100%	NA	NA
Discharge Status	98.5%	NA	NA
Service Start Date	99.3%	99.3%	97.8%
Service End Date	98.5%	99.3%	97.8%
Population	NA	99.3%	97.8%
Duration	NA	99.3%	97.8%
Staff Requirement	NA	99.3%	97.8%

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

Table 3-44 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 3-44—FY 2021–2022 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	90.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	90.0%	90.0%
Place of Service	NA	90.0%	100.0%
Service Category Modifier	NA	90.0%	100.0%
Units	NA	90.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	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	100.0%	90.0%	100.0%
Service End Date	100.0%	90.0%	100.0%
Population	NA	90.0%	100.0%
Duration	NA	90.0%	100.0%
Staff Requirement	NA	90.0%	100.0%

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

HCI: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for HCI:

- HCI reported relatively 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 all six data elements within inpatient services and nine of the 10 data elements within residential services.

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

HSAG found the following opportunities for improvement:

- For the *place of service* data element for psychotherapy services, HCI's self-reported EDV results demonstrated a low level of encounter data accuracy at 84.7 percent when compared to the corresponding medical records.

To address the opportunities for improvement, HSAG recommends:

- As such, HCI may consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among.

CAHPS Survey

HCI: Adult CAHPS

Table 3-45 shows the adult CAHPS results for HCI for FY 2021–2022.

Table 3-45—FY 2021–2022 Adult CAHPS Top-Box Scores for HCI

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	53.4% ↓	55.2% ↓
Rating of All Health Care	51.2%	56.5%
Rating of Personal Doctor	65.0%	66.2%
Rating of Specialist Seen Most Often	65.5%+	69.2%
Getting Needed Care	84.7%+	80.9%
Getting Care Quickly	86.3%+	78.9%
How Well Doctors Communicate	92.7%	91.3%
Customer Service	88.6%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

HCI: Strengths

The following measures' FY 2021–2022 scores for HCI were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

The following measures' FY 2021–2022 scores for HCI were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

- *Customer Service*

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

The following measure's FY 2021–2022 score for HCI was statistically significantly lower than the 2021 NCQA national average:

- *Rating of Health Plan*

The following measures' FY 2021–2022 scores for HCI were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

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

To address these low CAHPS scores, HSAG recommends HCI:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving a lower score for *Rating of Health Plan* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

HCI: Child CAHPS

Table 3-46 shows the child CAHPS results for HCI for FY 2021–2022.

Table 3-46—FY 2021–2022 Child CAHPS Top-Box Scores for HCI

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	68.3%	70.8%
Rating of All Health Care	56.2% ↓	65.1% ↓
Rating of Personal Doctor	73.7%	76.1%
Rating of Specialist Seen Most Often	76.0%+	70.9%
Getting Needed Care	81.0%+	80.2% ↓

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Getting Care Quickly	83.6%+	84.9%
How Well Doctors Communicate	95.4%	93.6%
Customer Service	82.0%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

HCI: Strengths

The following measures' FY 2021–2022 scores for HCI were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

The following measures' FY 2021–2022 scores for HCI were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *How Well Doctors Communicate*

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

The following measure's FY 2021–2022 score for HCI was statistically significantly lower than the 2021 NCQA national average:

- *Rating of All Health Care*

The following measures' FY 2021–2022 scores for HCI were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of All Health Care*

- *Rating of Personal Doctor*
- *Getting Care Quickly*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends HCI:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving a lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Quality Improvement Plan

HCI did not self-report any service coding accuracy scores below the 90 percent accuracy threshold; therefore, HCI was not required to participate in the FY 2021–2022 QUIP.

Mental Health Parity Audit

Table 3-47 displays the MHP Audit compliance scores for HCI for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-47—FY 2021–2022 MHP Audit Score for HCI

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
HCI	4	99%	Inpatient	96%	94%∨
			Outpatient	88%	

∨ *Indicates that the score declined as compared to the previous review year.*

HCI: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for HCI:

- HCI delegated UM activities to Beacon and followed policies and procedures regarding adequate monitoring and oversight of the delegated UM activities.

- HCI demonstrated that Beacon used nationally recognized UR criteria, including InterQual UR criteria, for MH determinations and outpatient SUD determinations, and ASAM level of care criteria for inpatient and residential SUD determinations.
- Beacon followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually, including requiring an 80 percent passing score.
- Beacon followed policies and procedures related to which services require prior authorization and provided notices to the member and provider in all cases reviewed.
- NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all required information.
- During the MHP interview, HCI reported several best practices related to implementation of the new SUD inpatient and residential benefit package starting in 2021, including monthly and quarterly provider forums, individualized training for providers as needed, provider newsletter content that includes new codes or changes to coding requirements, no longer declining to accept provider applications based on network sufficiency in a particular area, and utilization of the state-developed uniform service request form for SUD services.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- UR criteria used for the denial determinations were not properly documented in two outpatient files. In addition, the system notes did not clearly document which criteria were not met to result in the determination of not medically necessary within one inpatient file.
- In cases involving a medical necessity review, HCI did not consistently offer peer-to-peer reviews prior to finalizing a denial determination.
- NABD templates were minimally compliant regarding the reason and rationale to the member.
- During the MHP interview, Beacon staff members reported that referral to care coordination is not typically made after a denial determination and the care coordination department is not copied on or notified of the denial. Additionally, Beacon staff members reported that, per the UM workflow, members/families are required to request MH residential treatment level of care, and Beacon does not respond to provider referrals for MH residential treatment level of care.

To address these opportunities for improvement, HSAG recommends HCI:

- Enhance monitoring mechanisms to ensure UR criteria used for denial determinations are properly and clearly documented.
- Evaluate documentation protocols to ensure accuracy of documenting whether peer-to-peer reviews were offered.
- Add additional information to the reason and rationale for the denial so that members may better understand the circumstances surrounding the denial of services.
- Collaborate with Beacon to develop a process for making care coordination referrals when needed to ensure appropriate services are arranged when services needed differ from services requested and denied. Additionally, Beacon must evaluate the UM workflow and assess any possible care gaps.

Quality of Care Concern Audit

HCI used an internally developed definition for QOC issues. HCI submitted a national *Member Safety Program Policy and Procedure* for review. The definition was stated in policy. HCI had a total of six substantiated cases reported during the review period and used a five-level rating system to define the severity of QOC issues. HCI's national *Member Safety Program Policy and Procedure* stated the definitions for each severity level. Professionals with varying qualifications and/or degrees reviewed QOC issues submitted to HCI.

The following trends were identified within the sample cases reviewed:

- Four cases had a severity level of moderate, one was minimal, and one was major.
- Three out of six cases were related to an occurrence representing actual or potential serious harm to a member.
- Four out of six case outcomes resulted in a CAP for the provider/facility.
- HCI staff members stated that the member's race, ethnicity, or disability status are not collected on the form as part of the QOC review; therefore, HCI did not provide this information for sample cases reviewed for the audit.
- HCI had a system for identifying and addressing all alleged QOC issues. When a concern was raised, HCI investigated, analyzed, tracked, trended, and resolved QOC issues according to policy. HCI adhered to a national policy titled *Member Safety Program Policy and Procedure* and a Colorado-specific policy addendum titled *Member Safety Program—Serious Reportable Event, QOC Issues, and Outlier Practice Patterns.* Based on review of six sample cases and associated documents, HSAG determined that HCI adhered to its internal policies and procedures.
- One of the sample cases reviewed had an outcome reported to the Office of Behavioral Health (OBH). HCI's Colorado-specific policy provided a process for reporting to any regulatory agency, which stated that for cases where the QOC issue is substantiated and the occurrence is clearly outside of accepted standards of practice, the QM specialist conducting the investigation will

request the QOC Committee to make a recommendation for reporting the occurrence to the state licensing board or appropriate regulatory agency. If the QOCC recommends reporting a provider to the state licensing board/regulatory agency, the PR director will take that recommendation to the Credentialing Committee for review; if the committee concurs with the recommendation, the PR director will submit the recommendation to the national Credentialing Committee for further action. In cases where the provider is not in the network (e.g., single case agreement or recent network resignation), the QM specialist will prepare a report to the state licensing board/regulatory agency and submit to Beacon's legal department for approval prior to sending the report.

HCI: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for HCI:

- The *Health First Colorado Member Handbook* and information on the MCE's website included information for the member about the process for reporting a grievance. For the members' ease of understanding, the member materials did not distinguish the difference between a grievance and a QOCG.
- The *Colorado Medicaid Provider Handbook* provided examples of QOC issues and reminded providers that they are required to respond to inquiries, assist with investigations, provide CAPs when requested, and report progress toward addressing concerns through corrective actions as requested. A link to an Adverse Incident/Quality of Care Report form was available on the MCE's website.
- HCI's national *Member Safety Program Policy and Procedure* stated that investigations are expected to be completed within 60 calendar days from the date reported to HCI. Some milestone dates were also identified. For example, if the QOC issue is potentially urgent, the investigation must be initiated within one to two business days of receipt. Also, QOC issues assigned a risk rating of two or moderate risk have an investigation of the occurrence initiated within 14 calendar days of receipt, while those assigned an initial rating of one or low risk have an investigation initiated within 30 calendar days of receipt. HCI's QualityConnect system tracks the timing and alerts staff when the 60-calendar-day mark is approaching.
- For three of the six sample cases reviewed, HCI required the provider/facility to implement a CAP. QM staff members monitor CAP status and the effectiveness of the CAP to ensure the facility/provider do not have any further substantiated QOC issues of the same type for the current calendar year.
- As needed, and according to policy, HCI reviewed QOC issues with the following:
  - Professional (peer) review committee
  - HCI's legal department
  - Credentialing Committee
  - Beacon's Executive Medical Management Committee

- HCI reported that it began reporting all closed cases to the Department in October 2021. For this reporting, QM staff members prepared a QOC Process Spreadsheet, which was sent to the Department quarterly.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

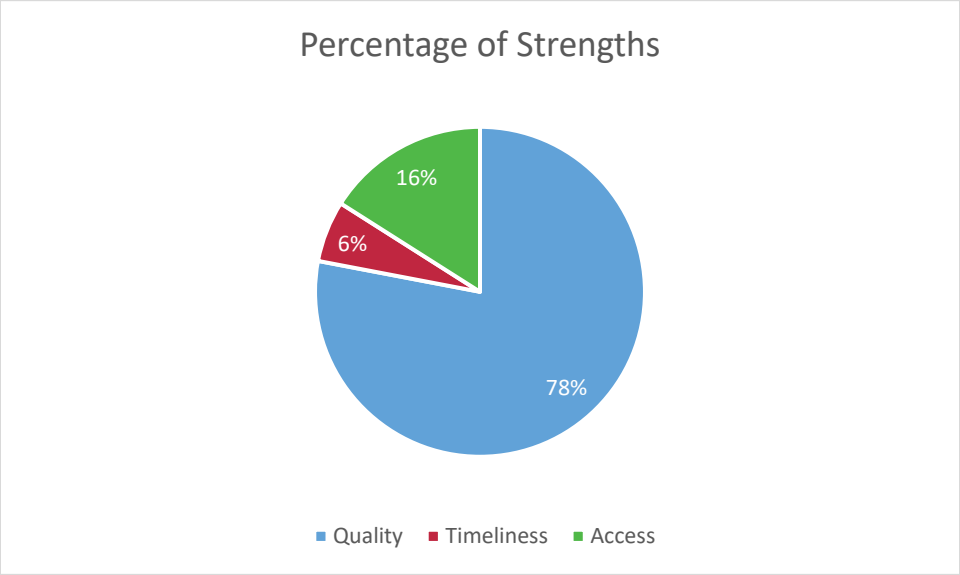
- HCI developed a PQI form. The PQI form documented points based on the severity level of the QOC issue. The form also provided a sum of points accrued in the last 24 months for the particular provider/facility. Once a threshold of seven points in a 24-month period has been reached, a referral will be made by the QOCC to the Credentialing Committee. If the Credentialing Committee concurs with the recommendation, the PR director will submit the recommendation to the national Credentialing Committee for further action. This process was recently implemented and therefore all sample cases reviewed did not include the PQI form. Additionally, this process was not described in policies and procedures submitted for review. HCI staff members also reported that the PQI form is not used if a case is part of the State's crisis services vendor contract. The PQI form is for providers directly contracted with HCI to use for monitoring and tracking purposes.
- HCI staff members stated that QOC issue training was not held regularly. However, all new staff members receive the training during their onboarding process.

To address these opportunities for improvement, HSAG recommends HCI:

- Implement ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Include the PQI form and point system process.
  - Include a process for sending acknowledgment and resolution letters to any party reporting a QOC issue.
  - Add severity levels and definitions.
  - Include information about the goal for completing QOC investigations.
- Continue notifying the Department of QOC issues received. Additionally, HCI should reach out to the Department to report ad hoc cases with severity, systematic concerns, and termination of any network provider.
- Continue to work in tandem with the grievance coordinator/OMFA.
- Consider integrating member information such as race, ethnicity, and disability status into the QOC database or merging with available demographic data to monitor for issues or trends.

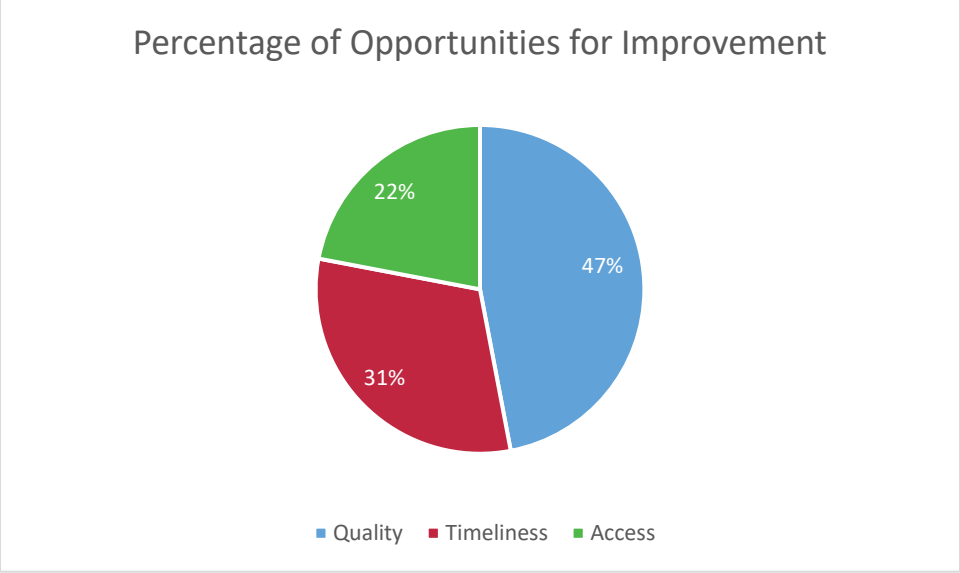
Region 5—Colorado Access

Figure 3-9—Percentage of Strengths by Care Domain for COA Region 5*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-10—Percentage of Opportunities for Improvement by Care Domain for COA Region 5*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are COA Region 5's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, COA Region 5 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, COA Region 5 established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-48 and Table 3-49 summarize COA Region 5's PIP activities that were completed and validated in FY 2020–2021. Table 3-48 provides the SMART Aim statements that COA Region 5 defined for the two PIP outcome measures in Module 1.

Table 3-48—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for COA Region 5

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%.

Table 3-49 summarizes the preliminary key drivers and potential interventions COA Region 5 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-49—Preliminary Key Drivers and Potential Interventions 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 BH referral process. • Provider education on appropriate BH follow-up coding practices. • Internal and external provider availability for BH 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 BH and referral resources.

FY 2021–2022 PIP Activities

In FY 2021–2022, COA Region 5 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, COA Region 5 developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, COA Region 5 submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as COA Region 5 carried out PDSA cycles to evaluate intervention effectiveness. Table 3-50 presents the FY 2021–2022 Module 3 validation findings for COA Region 5's four interventions.

Table 3-50—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Inner City Health Center workflow and coding changes to more accurately capture all depression screening services being performed for members and to better monitor depression screening performance	• Provider does not bill for depression screen • EHR errors	• Financial stability and billing accuracy • Standards of care: consistency at clinic and provider level on coding, provider education, and training	• Percentage of depression screening claims (CPT code G8510 or G8431) from Inner City Health Center with a corresponding diagnosis code of Z13.31 (depression screening encounter) in the health record
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of EHR to support protocol and coding standardization, using automation where possible	• Providers not aware of appropriate specification codes for the follow-up visit	• Financial stability and billing accuracy • Standards of care: provider education, follow-up coding, and training	• Percentage of well visits with a positive depression screening result, indicated by code G8431, with a follow-up service within 30 days, indicated by code H0002
A two-pronged approach to expanding BH services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the VCCI program for follow-up BH services via telehealth	• Follow-up visit is not occurring within 30 days of positive screen • Member is not reached for follow-up BH services • BH needs are not communicated to BH provider	• Standards of care: efficient referral processes • Internal and external BH provider availability • Financial stability and billing accuracy • Member access, knowledge, and engagement	• Percentage of available hiring and retention bonuses received by future and/or current BH staff (multiple measures) • Percentage of consults and therapy/assessments conducted via telehealth through the VCCI program (multiple measures)
Revise patient educational materials, MA scripting, and screening tool format at Inner City Health Center to promote depression screening and follow-up BH services and reduce member hesitancy to receiving services	• Member mental health needs are not identified • Member does not finish depression screening tool (PHQ-9) • Member with identified BH needs is not reached for follow-up	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Members are educated about treatment options and engaged	• Percentage of members who were offered a depression screening and decline the screening • Percentage of members who were offered BH follow-up services and decline the follow-up services • Percentage of members who were offered a

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
	• Provider is unaware of unmet BH needs	• Member access, knowledge, and engagement	depression screening or BH follow-up and who received a treatment hesitancy educational flyer

In Module 3, COA Region 5 selected four interventions to test for the PIP. The interventions addressed process failures in clinic workflows, coding practices, BH provider availability, and member willingness to receive BH services. For each intervention, COA Region 5 defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, COA Region 5 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- Selected four interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of four interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. COA Region 5 addressed all Module 3 PIP validation criteria.

To support successful progression of COA Region 5's PIP in the next fiscal year, HSAG recommends:

- COA Region 5 collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- COA Region 5 ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, COA Region 5 should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, COA Region 5 should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-51 shows the performance measure results for COA Region 5 for MY 2019 through MY 2021.

Table 3-51—Performance Measure Results for COA Region 5

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	43.54%	35.29%	36.65%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	63.56%	73.69%	56.03%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	37.22%	37.42%	35.25%	48.22%
Follow-Up After a Positive Depression Screen	32.20%	45.87%	39.21%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	17.20%	20.79%	28.57%	30.56%

COA Region 5: Strengths

The following performance measure rates for MY 2021 increased from the previous year for COA Region 5:

- *Engagement in Outpatient SUD Treatment*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 5 Overall Evaluation

Table 3-52 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 2021–2022.

Table 3-52—Summary of COA Region 5 Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	18	17	1	0	0	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**40**	**1**	**0**	**0**	**98%**

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

Table 3-53—Compliance With Regulations—Trended Performance for COA Region 5

Standard and Applicable Review Years*	COA Region 5 Average—Previous Review	COA Region 5 Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	80%	
Standard II—Access and Availability (2019–2020)	100%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**91%**	**100%**
Standard IV—Member Rights, Protections and (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**94%**	**94%**
Standard VI—Grievance and Appeal Systems (2019–2020)	83%	
Standard VII—Provider Selection and Program Integrity (2020–2021)	100%	

Standard and Applicable Review Years*	COA Region 5 Average—Previous Review	COA Region 5 Average—Most Recent Review**
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	100%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**88%**	**100%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, each of the standards reviewed for COA Region 5 demonstrated consistent high-achieving or improved scores from the previous review year, indicating a strong understanding of most federal and State regulations.

COA Region 5: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- COA Region 5's care coordination teams were multi-disciplinary staff members and organized by PH, BH, and resource and referral teams, tailored to the target population, such as members in foster care. These teams included mostly professionally licensed staff, such as BH professionals and RNs.
- COA Region 5's website and provider manual offered information on diversity and cultural training programs that foster respect and appreciation of differences in perspectives, beliefs, backgrounds, race, and sexual orientation. Additionally, the training program available to COA Region 5 staff members and providers included details to promote culturally sensitive services.
- COA Region 5 had robust processes to ensure that specific documents available electronically on the COA Region 5 website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the W3C Web Content Accessibility Guidelines.
- COA Region 5 submitted detailed documents that demonstrated adherence with a multi-stream outreach approach to engage and inform pregnant members and members ages 20 and under about EPSDT benefits.

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

HSAG found the following opportunities for improvement:

- COA Region 5 did not send any follow-up information after the care coordination outreach call detailing information provided over the phone to the member.
- COA Region 5's policy to submit an ADA complaint and receive a resolution did not clearly outline information regarding that COA Region 5 must resolve the grievance within the state-required time frames and staff members may assist the member in submitting a complaint with the Office of Civil Rights.
- The *New Member Booklet* contained some but not all required information. COA Region 5 did not inform members that auxiliary aids provided would be at no cost to the member or that critical materials can be printed and mailed within five business days.
- COA Region 5's policies and procedures did not have current federal language regarding the timeline to notify members of a provider termination, which was updated in December 2020 to include "or 30 days prior to the effective date of termination."

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Consider sending a follow-up letter to the member detailing the information provided during the care coordination outreach call should the member want to reach out to their care coordinator.
- Update the applicable policy to clarify that if a member submits a complaint with COA Region 5, COA Region 5 must resolve the grievance within the state-required time frames. HSAG also recommends COA Region 5 clarify that staff members may assist the member in submitting a complaint with the Office of Civil Rights and that the timelines and appeal procedures listed in the policy are consistent.
- Include full details regarding auxiliary aids in COA Region 5's *New Member Booklet* and inform members of their right to receive documents in paper format within five business days on websites where critical member materials are posted.
- Update the applicable policies and procedures to include the language "or 30 days prior to the effective date of the termination" when notifying the member of a provider termination.

Validation of Network Adequacy

COA Region 5: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- COA Region 5 met all minimum time and distance network requirement for Adult, Family and Pediatric Primary Care Practitioners (MD, DO, NP,CNS), Adult, Family and Pediatric Primary Care Practitioners (PA), and Gynecology OB/GYN (MD, DO, NP, CNS).

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

HSAG found the following opportunities for improvement:

- COA Region 5 did not meet the minimum time and distance network requirements for Gynecology OB/GYN (PA).

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-54 presents COA Region 5's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-54—FY 2021–2022 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	72.3%	98.5%
Principal Surgical Procedure Code	97.8%	NA	NA
Diagnosis Code	85.4%	84.7%	97.1%
Place of Service	NA	72.3%	99.3%
Service Category Modifier	NA	72.3%	98.5%
Units	NA	89.1%	99.3%
Revenue Code	92.7%	NA	NA

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Discharge Status	94.2%	NA	NA
Service Start Date	92.7%	93.4%	99.3%
Service End Date	98.5%	94.2%	99.3%
Population	NA	94.2%	99.3%
Duration	NA	85.4%	99.3%
Staff Requirement	NA	81.8%	99.3%

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

Table 3-55 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 3-55—FY 2021–2022 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	100.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	100.0%	100.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	90.0%	100.0%

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

COA Region 5: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- 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, nine of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While over-read results suggest confidence in COA Region 5's EDV results, some of COA Region 5's self-reported EDV results for psychotherapy services themselves demonstrated a moderate level of encounter data accuracy, including 72.3 percent accuracy for the *procedure code*, *place of service*, and *service category modifier* data elements.

To address the opportunities for improvement, HSAG recommends COA Region 5:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

COA Region 5: Adult CAHPS

Table 3-56 shows the adult CAHPS results for COA Region 5 for FY 2021–2022.

Table 3-56—FY 2021–2022 Adult CAHPS Top-Box Scores for COA Region 5

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	57.4%	55.2% ↓
Rating of All Health Care	52.5%+	56.5%
Rating of Personal Doctor	76.2% ▲	66.2%
Rating of Specialist Seen Most Often	69.9%+	69.2%
Getting Needed Care	78.6%+	80.9%
Getting Care Quickly	78.8%+	78.9%
How Well Doctors Communicate	94.0%+	91.3%
Customer Service	84.3%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

COA Region 5: Strengths

The following measures' FY 2021–2022 scores for COA Region 5 were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

The following measure's FY 2021–2022 score for COA Region 5 was statistically significantly higher than the statewide average score for FY 2021–2022:

- *Rating of Personal Doctor*

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

The following measures' FY 2021–2022 scores for COA Region 5 were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

The following measures' FY 2021–2022 scores for COA Region 5 were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

To address these low CAHPS scores, HSAG recommends COA Region 5:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be

driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.

- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

COA Region 5: Child CAHPS

Table 3-57 shows the child CAHPS results for COA Region 5 for FY 2021–2022.

Table 3-57—FY 2021–2022 Child CAHPS Top-Box Scores for COA Region 5

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	75.6%	70.8%
Rating of All Health Care	71.8%	65.1% ↓
Rating of Personal Doctor	84.1% ↑	76.1%
Rating of Specialist Seen Most Often	75.6%+	70.9%
Getting Needed Care	80.4%	80.2% ↓
Getting Care Quickly	84.4%+	84.9%
How Well Doctors Communicate	92.7%	93.6%
Customer Service	89.1%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

COA Region 5: Strengths

The following measure's FY 2021–2022 score for COA Region 5 was statistically significantly higher than the 2021 NCQA national average:

- *Rating of Personal Doctor*

The following measures' FY 2021–2022 scores for COA Region 5 were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Customer Service*

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

The following measures' FY 2021–2022 scores for COA Region 5 were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

The following measures' FY 2021–2022 scores for COA Region 5 were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

To address these low CAHPS scores, HSAG recommends COA Region 5:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.

Quality Improvement Plan

Table 3-58 presents COA Region 5's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-58—Summary of COA Region 5 QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Psychotherapy	Procedure Code	35.8%	100%	100%	100%
	Diagnosis Code	81.8%	100%	100%	100%
	Place of Service	72.3%	100%	50%	100%
	Service Category Modifier	35.8%	100%	100%	100%
	Duration	85.5%	100%	100%	100%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

COA Region 5: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- COA reached 100 percent accuracy for all five encounter data types by the end of the QUIP.
- Nearly all encounter data types improved to 100 percent accuracy in month one and maintained it in months two and three.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- Incomplete or incorrect documentation, such as missing place of service documentation in one chart in month two.

To address these opportunities for improvement, HSAG recommends:

- Continuing to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-59 displays the MHP Audit compliance scores for COA Region 5 for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-59—FY 2021–2022 MHP Audit Score for COA Region 5

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
COA Region 5	5	98%	Inpatient	99%	99%^
			Outpatient	100%	

^ *Indicates that the score increased as compared to the previous review year.*

COA Region 5: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- COA Region 5 demonstrated an increase in the compliance score by one percentage point compared to the previous review year and scored 100 percent compliance for all outpatient denial records reviewed.
- COA Region 5 consistently used nationally recognized UR criteria including InterQual UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations.
- COA Region 5 followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually including requiring a 90 percent passing score. Additionally, COA Region 5 followed policies and procedures related to which services require prior authorization and providing notices to the member and the provider.
- Most NABDs were sent to the member within the required time frame.
- All NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all required information.
- COA Region 5 offered requesting providers peer-to-peer reviews prior to finalizing a denial determination for all cases involving a medical necessity review.
- COA Region 5 used several best practices to implement the new SUD benefits.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- COA Region 5 did not send the NABD for one inpatient expediated determination within the 72-hour time frame.
- COA Region 5 did not include the specific name of the criteria (InterQual, ASAM, etc.) used within the NABD.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Ensure all NABDs are sent within the required time frame, and if the determination occurs during a weekend or holiday, the determination is referred to the proper personnel.
- Include within the NABD the specific name of the criteria used to make the denial determination.

Quality of Care Concern Audit

COA Region 5 used an internally developed definition for QOCCs. COA Region 5 submitted a *Quality of Care Concern* desk procedure along with a *Quality-of-Care Concern Investigation Policy and Procedure*. The definition stated in policy is similar. COA Region 5 had a total of 15 substantiated cases reported during the review period and used a four-level rating system to define the severity of QOCCs. COA Region 5's policy did not define the severity levels; however, COA Region 5's *Quality-of-Care Concern* desk procedure defined each severity level. Professionals with varying qualifications and/or degrees reviewed QOCCs submitted by COA Region 5.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, five members were White and five were not Hispanic or Latino.
- Three out of 10 members were disabled.
- Five cases had level two severity, four were a level one, and one case was a level three.
- Six cases were related to lack of follow-up/discharge planning.
- Four out of 10 case outcomes resulted in a CAP for the provider/facility, one of which was initiated by the Department.
- COA Region 5 had a system for identifying and addressing all alleged QOC concerns. When a concern was raised, COA Region 5 investigated, analyzed, tracked, trended, and resolved QOC concerns according to policy. COA Region 5 adhered to a COA Region 5 policy titled *Quality-of-Care Concern Investigation Policy and Procedure*. In addition to the policy, the RAE adhered to a *Quality-of-Care Concern* desk procedure, which provided direction for handling and reviewing QOC concerns. Based on review of 10 sample cases and associated documents, HSAG determined that COA Region 5 adhered to its internal policies and procedures.

- One case had a referral made by the Department to a child abuse hotline. COA Region 5 did not report any outcomes to a regulatory agency. COA Region 5's policy stated that the QM department will report to the chief compliance officer any issues that may need to be reported to an appropriate regulatory agency or state licensing board and child or adult protective services for further research, review, or action.

COA Region 5: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for COA Region 5:

- COA Region 5's QM department investigated and resolved concerns directly related to the quality of the medical care or BH care of a member. Policies described a process whereby the QM department, with oversight by a medical director or physician designee, would investigate, analyze, track, trend, and resolve QOCCs.
- The *Health First Colorado Member Handbook* and information on the RAE's website included information for the member about the process for reporting a grievance. Members were instructed to speak with their provider, the RAE, and/or Ombudsman. The member materials did not distinguish the difference between a grievance and a QOCG.
- If a grievance was clinical care-based and believed to meet the qualifications of a potential QOCC, the grievance team would send the grievance to the QM department to confirm the concern meets the threshold of a QOCC. The grievance could also be split between the QM department and grievance department if only parts of the complaint meet the threshold of a QOCC.
- The provider manual included definitions of a QOCC and critical incident. The manual also included information for reporting potential QOCCs and critical incidents and that reporting a potential concern or incident is confidential. COA Region 5 provided evidence of a provider newsletter that was sent via email to all providers on December 9, 2021. The newsletter provided information about a new form that should be utilized for reporting concerns and/or incidents. The *Quality of Care and Critical Incident Notification* form was linked on COA Region 5's website and could be emailed to the QOC email inbox at COA Region 5.
- COA Region 5 had letter and form templates that were clear and concise. Additionally, if a CAP needed to be developed, a helpful tips guide for developing a CAP was given to the provider/facility, along with a CAP template. Acknowledgment and resolution notification were sent to the individual who reported/initiated, which may or may not be internal COA staff.
- Throughout the sample case review and interview discussion, COA Region 5 demonstrated a collaborative approach with facilities and/or providers if an intervention or CAP was needed. COA Region 5 provided an education letter and/or conducted one-on-one meetings with providers to guide them through the CAP. COA Region 5 staff members stated they would continue to monitor

the facility/provider to ensure the QOCC volume decreases as a means of monitoring the effectiveness of the intervention or CAP.

- As needed, and according to policy, COA Region 5 reviewed QOCCs with the following:
  - External professional review (peer review)
  - Compliance department
  - COA Region 5's legal department
  - Credentialing Committee
- COA Region 5 staff members stated that care managers and UM coordinators participate in a QOCC training. Additionally, COA Region 5 staff members reported that an increase in volume of QOCCs was noted after the training; however, this increase was expected.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

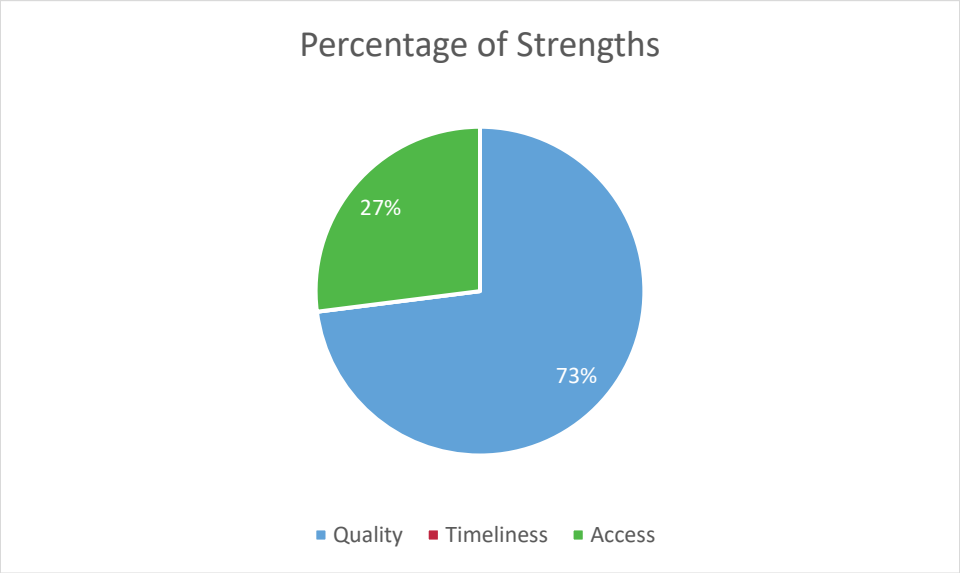
- COA Region 5 staff members reported that the QM team and grievance team work in tandem if the QOCC is reported by a member/member advocate. However, possible gaps could exist if the QM team investigates the QOCC but the grievance team sends the acknowledgment and resolution letters. For the QOCC tracking, the QM team did not capture dates or other evidence that these letters were sent by the grievance team.
- At the time of this audit, COA Region 5 did not have timelines or time frames for the QOCC process outlined in policy. During the interview, staff members indicated that the RAE's goal is for 90 percent of QOCCs to be closed in 90 days.
- COA Region 5's policy included information for monitoring trends that emerge from QOCC notifications. Staff members reported that the QM department trends information on an ongoing basis and reports the occurrence of QOCCs annually in the quality report, which is ultimately reported to the Department. Additionally, COA Region 5 reported to the Department if the Department requested or if a severe or systemic concern was identified. One sample case reviewed had been referred to COA Region 5 by the Department. The QOCC was investigated by COA Region 5 and reported to the Department according to contractual requirements.
- COA Region 5 staff members stated they would like for the Department to guide the RAEs through the required QOCC process, especially with the notification and reporting requirements.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Continue ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Incorporate contract requirements.
  - Include a process for reporting to the Department.
  - Include information about the goal for the completing QOC investigations.
- Should have its QM department continue to work in tandem with the grievance department to send out acknowledgment and resolution letters to members/member advocates. Additionally, COA Region 5 could implement a process for QOCC tracking to capture dates or other evidence that these letters were sent by the grievance team.
- Develop a more regular reporting process to notify the Department of QOCCs received, according to contractual requirements. Currently, COA Region 5 is reporting this information to the Department annually.

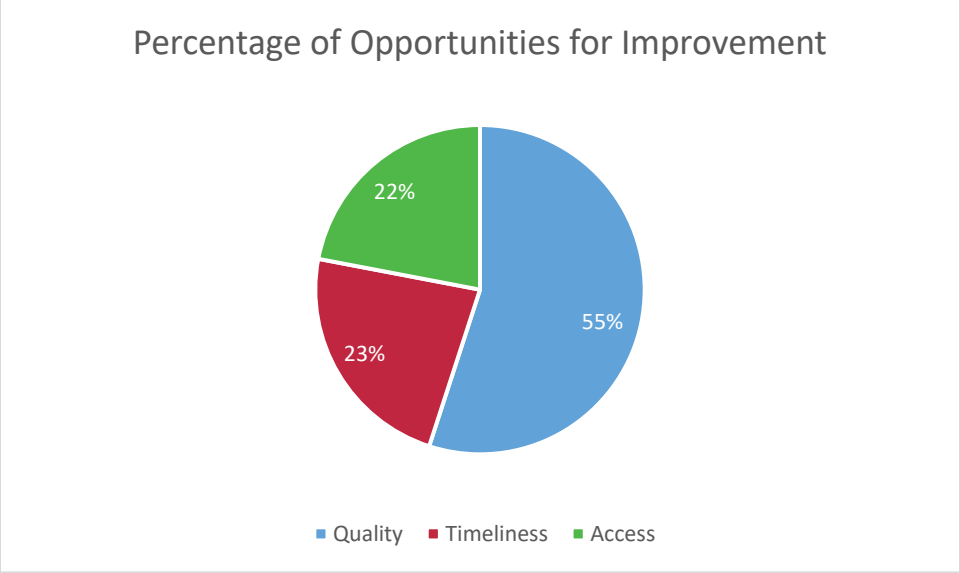
Region 6—Colorado Community Health Alliance

Figure 3-11—Percentage of Strengths by Care Domain for CCHA Region 6*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-12—Percentage of Opportunities for Improvement by Care Domain for CCHA Region 6*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are CCHA Region 6's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, CCHA Region 6 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, CCHA Region 6 established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-60 and Table 3-61 summarize CCHA Region 6's PIP activities that were completed and validated in FY 2020–2021. Table 3-60 provides the SMART Aim statements that CCHA Region 6 defined for the two PIP outcome measures in Module 1.

Table 3-60—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for CCHA Region 6

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 among unduplicated CCHA members 12 years or older from 49.27% to 53.01%.
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 BH service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years or older from 75.00% to 93.75%.

**The SMART Aim statement was revised in November 2021. HSAG approved revisions to the SMART Aim statement in November 2021 in response to CCHA Region 6's revised baseline data queries to accurately align with the project focus.*

Table 3-61 summarizes the preliminary key drivers and potential interventions CCHA Region 6 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-61—Preliminary Key Drivers and Potential Interventions 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

FY 2021–2022 PIP Activities

In FY 2021–2022, CCHA Region 6 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, CCHA Region 6 developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, CCHA Region 6 submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as CCHA Region 6 carried out PDSA cycles to evaluate intervention

effectiveness. Table 3-62 presents the FY 2021–2022 Module 3 validation findings for CCHA Region 6's two interventions.

Table 3-62—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Identify a virtual depression screening tool (PHQ-A)[1] for minors ages 12–17 years at Clinica Family Health, build an electronic PHQ-A form, and train Clinica staff to integrate the electronic screening tool into the virtual visit workflow	• Minors (ages 12–17 years) are not screened for depression when mode of delivery is virtual	• Provider Standards of Care: Adjust processes for remote services	• Percentage of members ages 12–17 years who attended a virtual outpatient primary care visit with Clinica and received a depression screening (G8431 or G8510) during the virtual visit
Develop a workflow for BH referral after a positive depression screen and train Clinica staff to consistently and successfully apply workflow to ensure members receive appropriate referral and follow-up	• Members with a positive depression screen are not referred for additional BH assessment and services	• Provider Standards of Care	• Percentage of members 12 years of age or older who had a positive depression screen at Clinica and who received a referral and BH service at Clinica within 30 days of the positive screen

[1]*PHQ = Patient Health Questionnaire*

In Module 3, CCHA Region 6 selected two interventions to test for the PIP. The interventions addressed process gaps or failures in both virtual and in-person clinic workflows for depression screening and follow-up services. For each intervention, CCHA Region 6 defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, CCHA Region 6 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- Selected two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. CCHA Region 6 addressed all Module 3 PIP validation criteria.

To support successful progression of CCHA Region 6's PIP in the next fiscal year, HSAG recommends:

- CCHA Region 6 collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- CCHA Region 6 ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, CCHA Region 6 should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, CCHA Region 6 should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-63 shows the performance measure results for CCHA Region 6 for MY 2019 through MY 2021.

Table 3-63—Performance Measure Results for CCHA Region 6

Performance Measure	MY 2019	MY 2020	MY2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	45.81%	46.37%	41.61%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	69.45%	77.93%	64.51%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	35.25%	35.41%	35.30%	48.22%
Follow-Up After a Positive Depression Screen	52.56%	61.75%	47.48%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.59%	21.51%	17.82%	30.56%

CCHA Region 6: Strengths

The following performance measure rates for MY 2021 increased from the previous year for CCHA Region 6:

- HSAG did not identify any strengths when conducting the PMV.

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

The following rates were below the Department-determined performance target:

- *Engagement in Outpatient SUD Treatment* 
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* 
- *Follow-Up Within 7 Days of an ED Visit for SUD* 
- *Follow-Up After a Positive Depression Screen* 
- *Behavioral Health Screening or Assessment for Children in the Foster Care System* 

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 6 Overall Evaluation

Table 3-64 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 2021–2022.

Table 3-64—Summary of CCHA Region 6 Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	9	1	0	0	90%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	15	13	2	0	3	87%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**38**	**34**	**4**	**0**	**3**	**89%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-65—Compliance With Regulations—Trended Performance for CCHA Region 6

Standard and Applicable Review Years*	CCHA Region 6 Average—Previous Review	CCHA Region 6 Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	83%	
Standard II—Access and Availability (2019–2020)	94%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**100%**	**90%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**86%**	**87%**
Standard VI—Grievance and Appeal Systems (2019–2020)	71%	
Standard VII—Provider Selection and Program Integrity (2020–2021)	100%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	100%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**75%**	**86%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, CCHA Region 6 demonstrated consistent high-achieving or improved scores from the previous review year for Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. However, Standard III—Coordination and Continuity of Care declined by 10 percentage points compared to the previous review year.

CCHA Region 6: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6's clinical care coordination team included diverse staff members ranging from RNs, social workers, BH care coordinators, care navigators, and outreach care/peer support specialists. Additionally, the clinical care coordination team worked with Member Support Services (MSS) to engage with members and deliver a "whole-person" care approach.

- CCHA Region 6 required staff members to complete privacy trainings on topics such as ethics, compliance, privacy, information security, and physical security and submitted evidence regarding these trainings.
- CCHA Region 6 used various avenues to help members understand the requirements and benefits of their plan. Members could refer to the CCHA website and *Map to Medicaid* guide for more information about benefits. Additionally, MSS staff members were available to help members understand their benefits.
- Educational materials for members, providers, and staff following the American Academy of Pediatrics *Bright Futures Guidelines* periodicity schedule for preventive healthcare informed members that CCHA Region 6 is available to arrange appointments, and offered assistance obtaining transportation services.

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

HSAG found the following opportunities for improvement:

- CCHA Region 6 staff members could not confirm the expected care coordination follow-up or outreach methods by entities such as Community Mental Health Centers (CMHCs) to outreach high-risk members. Additionally, UM staff members did not reference specific details/thresholds/rubrics considered to refer newly identified members after a denial of service(s) into care coordination.
- Care coordination policies, procedures, and Accountable Care Network (ACN) delegation agreements did not clearly describe PCMP expectations regarding referral procedures or timeliness for high-risk members or members in need of additional support.
- Critical informational materials did not include all required components of a tagline, and CCHA Region 6 did not confirm monitoring mechanisms in place to ensure that ad hoc printing requests are printed and mailed to members within five business days. Additionally, CCHA Region 6 did not confirm a monitoring mechanism to ensure that members received a written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination.
- CCHA Region 6's documents did not include information about its website to meet all required member information components.
- CCHA Region 6's website contained a few minor errors on the frequently asked questions (FAQ) webpage such as broken links to the Department's EPSDT information and some EPSDT informational details that included federal citations that were not member friendly.
- Submitted meeting minutes indicated some providers expressed concern when services for members were either not available or were denied and lower-level care was approved. Additionally,

CCHA Region 6 submitted limited documentation to verify how EPSDT considerations are processed within the UM department, and the plan reported issues identifying this member population in two out of the four quarters in the review period, CY 2021. 

- CCHA Region 6 did not outreach members who had not utilized EPSDT services in the previous 12 months during three of the four quarters in CY 2021. However, in the last quarter of CY 2021, CCHA Region 6 completed outreach to non-utilizers but noted an issue with data sorting procedures, which lead to inadvertently outreaching members who had utilized services in the previous 12-month period. 

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Enhance procedures as well as create a care coordination workflow to better detail how CCHA Region 6 processes and prioritizes referrals and/or service denials (in which a member may need additional coordination) to ensure follow-ups when needed.
- Strengthen applicable care coordination documents and create a more detailed procedure that outlines PCMP referral procedures; timeliness expectations; and how CCHA Region 6 ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP tier, or condition management capabilities.
- Develop a mechanism to track and ensure timeliness of provider termination notices; revise critical member materials to include all required components of a tagline; develop a mechanism to ensure that, upon request, members are provided printed materials within five business days; and communicate with the Department and CCHA Region 6 to ensure the updated welcome letter includes all required components, such as CCHA Region 6's website address.
- Ensure the accuracy and readability of website information prior to posting and reviewing links regularly as part of a best practice approach to maintaining EPSDT informational materials; expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process; develop a process to ensure access to foster care data so that corresponding outreach to newly eligible foster children is completed within 60 days of identification, either by DHS or CCHA Region 6; and continue annual EPSDT non-utilizer outreach procedures that were implemented at the end of CY 2021 and revisit QA procedures regarding the non-utilizer data set.

Validation of Network Adequacy

CCHA Region 6: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- While CCHA Region 6 did not meet all minimum time and distance network requirements across all counties in each county designation, General BH Practitioners had only one county in which it did not meet the standards and was less than 1 percent from meeting the standard.

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

HSAG found the following opportunities for improvement:

- CCHA Region 6 did not meet all minimum time and distance network requirements for Psychiatric Hospitals and all SUD ASAM levels across all contracted counties.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-66 presents CCHA Region 6's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-66—FY 2021–2022 Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 6

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	92.7%	97.8%
Principal Surgical Procedure Code	99.3%	NA	NA
Diagnosis Code	77.4%	89.1%	97.8%
Place of Service	NA	86.1%	76.6%
Service Category Modifier	NA	92.0%	97.8%
Units	NA	98.5%	97.8%
Revenue Code	94.2%	NA	NA

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Discharge Status	93.4%	NA	NA
Service Start Date	99.3%	99.3%	98.5%
Service End Date	99.3%	99.3%	98.5%
Population	NA	99.3%	99.3%
Duration	NA	99.3%	98.5%
Staff Requirement	NA	97.1%	98.5%

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

Table 3-67 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 3-67—FY 2021–2022 BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 6

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	90.0%	100.0%
Place of Service	NA	80.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	100.0%	100.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	100.0%	100.0%

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

CCHA Region 6: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- 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 all six inpatient services data elements, eight of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- For the *diagnosis code* data element for inpatient services, CCHA Region 6's self-reported EDV results demonstrated a low level of encounter data accuracy at 77.4 percent when compared to the corresponding medical records.

To address the opportunities for improvement, HSAG recommends CCHA Region 6:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

CCHA Region 6: Adult CAHPS

Table 3-68 shows the adult CAHPS results for CCHA Region 6 for FY 2021–2022.

Table 3-68—FY 2021–2022 Adult CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	59.0%	55.2% ↓
Rating of All Health Care	63.1%+	56.5%
Rating of Personal Doctor	69.7%	66.2%
Rating of Specialist Seen Most Often	67.0%+	69.2%
Getting Needed Care	85.2%+	80.9%
Getting Care Quickly	78.2%+	78.9%
How Well Doctors Communicate	91.2%+	91.3%
Customer Service	92.4%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

CCHA Region 6: Strengths

The following measures' FY 2021–2022 scores for CCHA Region 6 were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Getting Needed Care*
- *Customer Service*

The following measures' FY 2021–2022 scores for CCHA Region 6 were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Getting Needed Care*
- *Customer Service*

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

The following measures' FY 2021–2022 scores for CCHA Region 6 were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

The following measures' FY 2021–2022 scores for CCHA Region 6 were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

To address these low CAHPS scores, HSAG recommends CCHA Region 6:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.

CCHA Region 6: Child CAHPS

Table 3-69 shows the child CAHPS results for CCHA Region 6 for FY 2021–2022.

Table 3-69—FY 2021–2022 Child CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	71.8%	70.8%
Rating of All Health Care	70.5%	65.1% ↓
Rating of Personal Doctor	78.0%	76.1%
Rating of Specialist Seen Most Often	87.7%+ ↑	70.9%
Getting Needed Care	91.2%+ ▲	80.2% ↓
Getting Care Quickly	85.2%+	84.9%
How Well Doctors Communicate	95.6%	93.6%
Customer Service	85.1%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

CCHA Region 6: Strengths

The following measure's FY 2021–2022 score for CCHA Region 6 was statistically significantly higher than the 2021 NCQA national average:

- *Rating of Specialist Seen Most Often*

The following measure's FY 2021–2022 score for CCHA Region 6 was statistically significantly higher than the statewide average score for FY 2021–2022:

- *Getting Needed Care*

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

The following measures' FY 2021–2022 scores for CCHA Region 6 were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Getting Care Quickly*
- *Customer Service*

The following measure's FY 2021–2022 score for CCHA Region 6 was lower, although not statistically significantly, than the statewide average score for FY 2021–2022:

- *Customer Service*

To address these low CAHPS scores, HSAG recommends CCHA Region 6:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

Quality Improvement Plan

Table 3-70 presents CCHA Region 6's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-70—Summary of CCHA Region 6 QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Ambulatory Inpatient	Diagnosis Code	79.6%	100%	100%	100%
Psychotherapy	Procedure Code	89.8%	100%	100%	100%
	Service Category Modifier	89.8%	100%	100%	100%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

CCHA Region 6: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 reached 100 percent accuracy for all three encounter data types included in the QUIP for ambulatory inpatient and psychotherapy claim types and demonstrated that the QUIP interventions have been adopted in practice.
- Notably, all three encounter data types reached 100 percent accuracy by month one of the intervention period and sustained these scores for months two and three.
- CCHA Region 6 used a multifaceted approach in addressing low accuracy such as EHR software platform modifications, developing automated reports to identify records needing correction, reviewing the updated 411 Audit Guidelines document with providers, implementing a self-audit checklist, and conducting staff training on documentation requirements.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- Reasons for non-accuracy in baseline scores included missing technical documentation from audited records and provider misunderstanding of audited elements.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-71 displays the MHP Audit compliance scores for CCHA Region 6 for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-71—FY 2021–2022 MHP Audit Score for CCHA Region 6

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
CCHA Region 6	6	84%	Inpatient	82%	86%^
			Outpatient	91%	

^ *Indicates that the score increased as compared to the previous review year.*

CCHA Region 6: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 demonstrated an increase in the compliance score by two percentage points compared to the previous review year.
- The inpatient and outpatient records reviewed for CCHA Region 6 demonstrated that it used nationally recognized UR criteria. CCHA Region 6 used MCG UR criteria for all MH UR determinations and ASAM level of care criteria for all SUD determinations.
- Annually, CCHA Region 6 required UM staff members to pass IRR testing with a minimum score of 90 percent.
- In most cases, CCHA Region 6 offered requesting providers a peer-to-peer review for medical necessity denials prior to a final determination.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- UR criteria used for the denial determinations were not properly documented in two inpatient files.
- CCHA Region 6 did not consistently follow policies and procedures regarding the presence of a co-occurring MH diagnosis and whether the diagnosis was assessed or given consideration prior to a denial determination.
- Within applicable records, the records did not contain documentation that provided evidence of implementing the State's processes or procedures for referring specific denials to care coordination.
- CCHA Region 6 did not consistently offer peer-to-peer review with the requesting provider prior to a final determination.
- CCHA Region 6 revised the NABD template following the FY 2020–2021 MHP audit findings; however, in several instances, the previous template was used. The previous template included several typographical errors, and reasons and rationales were often confusing and difficult to understand.
- The NABD was never sent to the member for several inpatient and outpatient records. Additionally, CCHA Region 6 sent NABDs to members for provider procedural issues, and CCHA Region 6 staff members were unaware that members should not receive these notices.
- CCHA Region 6 did not consistently follow its policies and procedures, which was reflected in the total score of 86 percent.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Enhance monitoring mechanisms to ensure UR criteria used for denial determinations are properly documented.
- Evaluate processes and develop training on policies and procedures to ensure co-occurring diagnoses are assessed and given consideration prior to a denial determination.
- Develop training to ensure implementation of procedures regarding referrals to care coordination after a denial of service.
- Offer requesting providers peer-to-peer reviews prior to finalizing a denial determination for all cases involving a medical necessity review.
- Enhance monitoring mechanisms to ensure the correct NABD template is used and sent to the member within the required time frame.

- Provide training to ensure staff members are aware that members should not receive notices for provider procedural issues as interpretated in the BBA of 1997.
- Evaluate processes and develop training on procedures, Colorado-required processes, and the Medicaid managed care regulations to ensure the consistency of processes, documentation, and compliance with regulations.

Quality of Care Concern Audit

CCHA Region 6 used an internally developed definition for QOC issues. CCHA Region 6 submitted a *Quality-of-Care Procedure* for review and included the above definition. Additionally, CCHA Region 6 submitted a *Quality-of-Care Policy*; however, the policy did not include a definition. CCHA Region 6 had a total of 45 substantiated cases reported during the review period and used a six-level rating system to define the severity of QOC issues. CCHA Region 6's *Quality of Care Policy* defined the severity levels. Professionals with varying qualifications and/or degrees reviewed QOC issues submitted to CCHA Region 6.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, six were non-Hispanic White members.
- Four out of 10 members reported being disabled.
- Eight cases had level two severity, one was a level three, and one was a level four.
- Five out of 10 cases were related to a potentially harmful action to a member, four instances of treatment inconsistent with standards of practice, and one sentinel event.
- Two out of 10 case outcomes resulted in a CAP for the provider/facility.
- CCHA Region 6 had a system for identifying and addressing all alleged QOC issues. When a concern was raised, CCHA Region 6 investigated, analyzed, tracked, trended, and resolved QOC issues according to policy. CCHA Region 6 adhered to a CCHA Region 6 policy titled *Quality of Care Policy*. In addition to the policy, the RAE adhered to a procedure titled *Quality of Care Procedure*. The procedure provided direction for handling and reviewing QOC issues. Based on review of 10 sample cases and associated documents, HSAG determined that CCHA Region 6 adhered to its internal policies and procedures.
- None of the 10 sample cases reviewed had an outcome reported to a regulatory agency. CCHA Region 6's policy stated that additional actions for QOC issues may include reporting to the relevant Colorado Department of Regulatory Agencies, Professions, and Occupations board.

CCHA Region 6: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6's QM department was responsible for investigating and developing an intervention, as necessary, to ensure quality and appropriateness of care is rendered to members. The *Quality of Care Procedure* described a process whereby QOC issues were reviewed from identification until resolution.
- The *Health First Colorado Member Handbook* and information on the RAE's website included information for the member about the process for reporting a grievance. For the members' ease of understanding, the member materials did not distinguish the difference between a grievance and a QOCG.
- The provider manual included information about critical incident reporting and management and QOC. The information provided steps for reporting and a link to the form. Additionally, a link to the form was on CCHA Region 6's website. Within the CCHA Region 6 provider manual, providers were reminded that they must cooperate with any investigation conducted by CCHA Region 6 or an outside agency.
- CCHA Region 6 had letter and form templates that were clear and concise. Letters outlined the entire investigation and resolution findings in an easy to read format.
- As needed, and according to policy, CCHA Region 6 reviewed QOC issues with the following:
  - Peer Review Committee
  - Compliance department
  - CCHA Region 6's legal department
  - Credentialing Committee
- For the case samples reviewed that had a CAP initiated, CCHA Region 6 requested that the provider/facility submit supporting documentation related to the CAP. Additionally, CCHA Region 6 provided a CAP template within the letter. This process prompts the facility/provider to complete a thorough and meaningful plan and, partnered with CCHA Region 6 requesting evidence of the plan, should be considered a best practice of CCHA Region 6. Case samples reviewed provided evidence that CCHA Region 6 is requesting documentation based on the CAP developed.
- CCHA Region 6 provided evidence of a quarterly *Fiscal Year 2021–2022 Quality of Care Summary* that was sent to the Department. The report included a summary of referrals for the quarter, rolling 12-month data, and quarterly data for severity levels and types of QOC issues. Additionally, the report contained information on high volume providers and specific details for cases above a level three severity, along with the QM department's ongoing efforts. CCHA Region 6 staff members stated that if the Department would request additional information about a particular case, they would follow the RAE's contractual requirements.

- CCHA Region 6 staff members stated that an annual training for QOC issues, grievances, and appeals was provided and the RAE's goal is for staff members to feel comfortable reporting any issue. During the training, the QOC issue reporting process was reviewed. CCHA Region 6 provided evidence of the training that was held on January 24 and 25, 2022.
- In an effort to lessen provider burden, CCHA Region 6 will accept any form of critical or QOC issue reporting. Meaning, the provider is not required to use CCHA Region 6's form to report. However, CCHA Region 6 has made the form accessible for providers and ensures all information is captured about the potential incident.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

- During the interview, CCHA Region 6 staff members described the process for following up with the member to determine if immediate healthcare needs are being met and stated that the safety of the member is priority to CCHA Region 6. CCHA Region 6 staff members stated that care coordinators may outreach the member and follow up. However, this process was not described in policy or procedure.
- CCHA Region 6 staff members reported that the QM department and grievance team work in tandem if the QOC issue is reported by a member/member advocate. However, neither CCHA Region 6's policy nor procedure outlined a process to ensure acknowledgement and resolutions are distributed to the member/member advocate. Possible gaps between the QM department and grievance team could exist if the QM department entrusts the grievance team with this step and is not following up or capturing dates or other evidence that letters were distributed.
- At the time of this audit, CCHA Region 6 did not have timelines or time frames for the QOC investigation start to finish process outlined in policy or procedure. Additionally, CCHA Region 6 staff members stated they have not been tracking the process in order to identify a time frame. CCHA Region 6's procedure identified some specific timelines for egregious cases, in which the medical record request would be made within 72 hours (three business days) after receipt of the QOC issue, and the medical director has 72 hours (three business days) to make a determination. In all other cases, the medical director has 10 business days from the time of receipt to review the case and determine an outcome. Urgent cases must be reviewed within 72 hours (three business days) from the time of the referral. If a case has a preliminary severity level of five, the medical director will be scheduled for an emergency meeting of the QMC and will follow the peer review process within five calendar days of the assigned severity level. CCHA Region 6 staff members reported that providers not submitting medical records and/or additional information related to the case is a barrier to securing the records; providers are reluctant to submit records because they question CCHA Region 6's validity of the request due to CCHA Region 6 not being the payor of the claim.

CCHA Region 6's policy stated that CCHA Region 6 will resolve QOC issues within a timely manner, taking into consideration the clinical urgency of the situation.

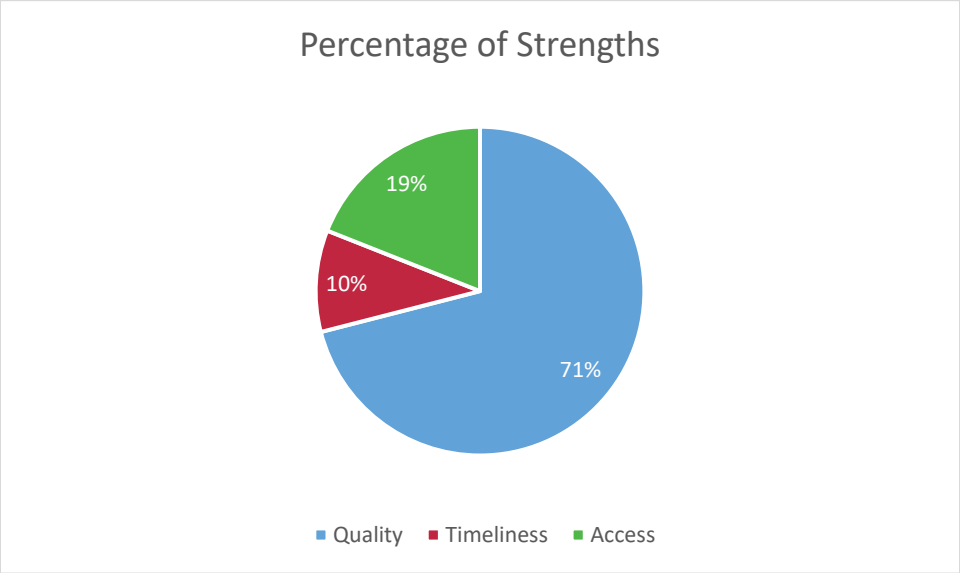
- CCHA Region 6 staff members requested that a better, more efficient process for trending, tracking, and uploading information to the Department be considered for the QOC issue process. Also, CCHA Region 6 is hoping a communication process is developed that notifies all MCEs if a systemic issue is identified amongst the facility and/or provider network.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Continue conducting staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Incorporate contract requirements.
  - Incorporate the process for reporting to the Department.
  - Establish a time frame and/or goals for the QOCG process.
- Continue requesting evidence of the CAP from a facility/provider when a CAP is initiated.
- Continue notifying the Department of QOC issues received and continue reaching out to the Department to report ad hoc cases of severity, systematic concerns, and termination of any network provider.
- Have its QM department continue to work in tandem with the grievance department to send out acknowledgment and resolution letters to members/member advocates. Additionally, CCHA Region 6 could implement a process for capturing dates or information from the letters that the grievance team distributes. This process will provide the QM department the verification that both acknowledgment and resolution letters were provided to the member/member advocate.

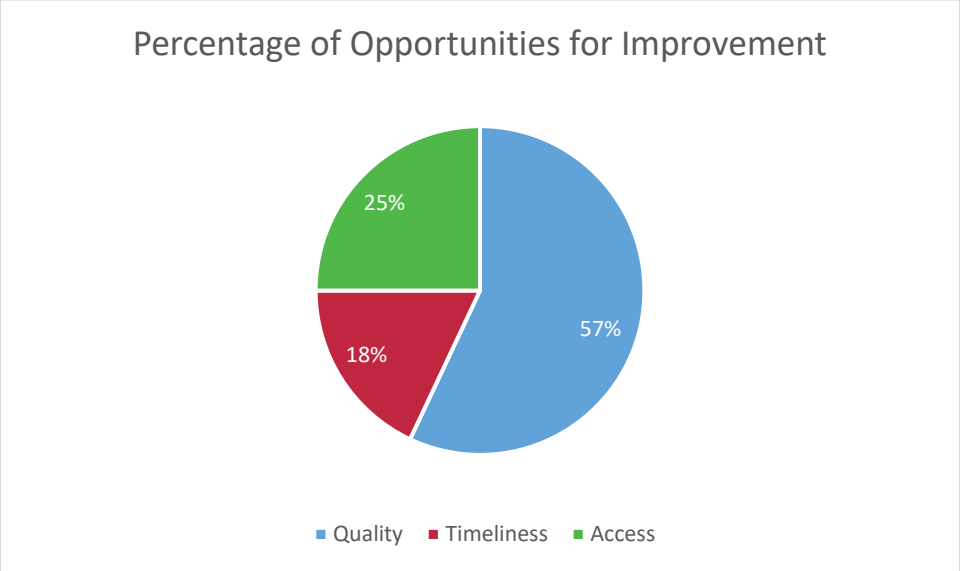
Region 7—Colorado Community Health Alliance

Figure 3-13—Percentage of Strengths by Care Domain for CCHA Region 7*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-14—Percentage of Opportunities for Improvement by Care Domain for CCHA Region 7*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are CCHA Region 7's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, CCHA Region 7 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, CCHA Region 7 established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-72 and Table 3-73 summarize CCHA Region 7's PIP activities that were completed and validated in FY 2020–2021. Table 3-72 provides the SMART Aim statements that CCHA Region 7 defined for the two PIP outcome measures in Module 1.

Table 3-72—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for CCHA Region 7

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 62.08% to 63.53%.
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 BH 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 72.10% to 75.74%.

**The SMART Aim statement was revised in November 2021. HSAG approved revisions to the SMART Aim statement in November 2021 in response to CCHA Region 7's revised baseline data queries to accurately align with the project focus.*

Table 3-73 summarizes the preliminary key drivers and potential interventions CCHA Region 7 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-73—Preliminary Key Drivers and Potential Interventions 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

FY 2021–2022 PIP Activities

In FY 2021–2022, CCHA Region 7 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, CCHA Region 7 developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, CCHA Region 7 submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as CCHA Region 7 carried out PDSA cycles to evaluate intervention effectiveness. Table 3-74 presents the FY 2021–2022 Module 3 validation findings for CCHA Region 7's two interventions.

Table 3-74—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Revise Peak Vista's depression screen coding protocol to include a category of "Watchful Waiting" for those members whose depression screen score does not warrant immediate follow-up care and adapt the EHR to require a follow-up option is selected (hard stop before exiting form) to ensure that each depression screen entered has a documented follow-up plan.	Procedure code selected for follow-up services may not be included in the list of eligible codes for the follow-up metric numerator	Data accuracy and integration	Percentage of depression screens categorized as "Watchful waiting; reassess at next visit" with a corresponding G8510 CPT code
Revise Peak Vista's depression screening (PHQ-9) script to guide providers in educating patients on the benefits of depression screening and help motivate members to complete the screening. The EHR depression screening forms were also adapted to capture member refusals and medical exclusions more consistently.	Members that refuse to complete the PHQ-9 form are not formally assessed for depression	Provider standards of care	Percentage of unique members 12 years or older who receive qualifying outpatient primary care services at Peak Vista and refuse a depression screen during the primary care service

In Module 3, CCHA Region 7 selected two interventions to test for the PIP. The interventions addressed process gaps or failures in completing the depression screening and coding and reporting depression screening results. For each intervention, CCHA Region 7 defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, CCHA Region 7 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- Selected two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. CCHA Region 7 addressed all Module 3 PIP validation criteria.

To support successful progression of CCHA Region 7's PIP in the next fiscal year, HSAG recommends:

- CCHA Region 7 collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- CCHA Region 7 ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, CCHA Region 7 should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, CCHA Region 7 should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Performance Measure Rates and Validation

Table 3-75 shows the performance measure results for CCHA Region 7 for MY 2019 through MY 2021.

Table 3-75—Performance Measure Results for CCHA Region 7

Performance Measure	MY 2019	MY 2020	MY 2021	MY 2021 Performance Target
Engagement in Outpatient SUD Treatment	55.01%	46.37%	54.10%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	72.90%	77.93%	41.42%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	37.01%	35.41%	32.75%	48.22%
Follow-Up After a Positive Depression Screen	59.18%	61.75%	73.39%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	19.47%	21.51%	23.29%	30.56%

CCHA Region 7: Strengths

The following performance measure rates for MY 2021 increased from the previous year for CCHA Region 7:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up After a Positive Depression Screen*
- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

Additionally, the following performance measure rates for MY 2021 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up After a Positive Depression Screen*

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

The following rates were below the Department-determined performance target:

- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* 
- *Follow-Up Within 7 Days of an ED Visit for SUD* 
- *Behavioral Health Screening or Assessment for Children in the Foster Care System* 

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Create a dashboard to monitor rates monthly or quarterly.
- Assess interventions that have been successful for similar indicators and apply them to others.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 7 Overall Evaluation

Table 3-76 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 2021–2022.

Table 3-76—Summary of CCHA Region 7 Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	9	1	0	0	90%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	15	13	2	0	3	87%
Standard XI—Early and Periodic Screening, Diagnostic and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**38**	**34**	**4**	**0**	**3**	**89%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

Table 3-77—Compliance With Regulations—Trended Performance for CCHA Region 7

Standard and Applicable Review Years*	CCHA Region 7 Average—Previous Review	CCHA Region 7 Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2019–2020)	87%	
Standard II—Access and Availability (2019–2020)	94%	
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	**100%**	**90%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2018–2019; 2021–2022)	**86%**	**87%**

Standard and Applicable Review Years*	CCHA Region 7 Average—Previous Review	CCHA Region 7 Average—Most Recent Review**
Standard VI—Grievance and Appeal Systems (2019–2020)	74%	
Standard VII—Provider Selection and Program Integrity (2020–2021)	100%	
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	100%	
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	100%	
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	**75%**	**86%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*
***Grey shading indicates standards where no previous comparison results are available.*

In FY 2021–2022, CCHA Region 7 demonstrated consistent high-achieving or improved scores from the previous review year for Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. However, Standard III—Coordination and Continuity of Care declined by 10 percentage points compared to the previous review year.

CCHA Region 7: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7's clinical care coordination team included diverse staff members ranging from RNs, social workers, BH care coordinators, care navigators, and outreach care/peer support specialists. Additionally, the clinical care coordination team worked with MSS to engage with members and deliver a "whole-person" care approach.
- CCHA Region 7 required staff members to complete privacy trainings on topics such as ethics, compliance, privacy, information security, and physical security and submitted evidence regarding these trainings.
- CCHA Region 7 used various avenues to help members understand the requirements and benefits of their plan. Members could refer to the CCHA website and Map to Medicaid guide for more information about benefits. Additionally, MSS staff members were available to help members understand their benefits.

- Educational materials for members, providers, and staff following the American Academy of Pediatrics *Bright Futures Guidelines* periodicity schedule for preventive healthcare informed members that CCHA is available to arrange appointments and offered assistance obtaining transportation services.

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

HSAG found the following opportunities for improvement:

- CCHA Region 7 staff members could not confirm the expected care coordination follow-up or outreach methods by entities such as CMHCs to outreach high-risk members. Additionally, UM staff members did not reference specific details/thresholds/rubrics considered to refer newly identified members after a denial of service(s) into care coordination.
- Care coordination policies, procedures, and ACN delegation agreements did not clearly describe PCMP expectations regarding referral procedures or timeliness for high-risk members or members in need of additional support.
- Critical informational materials did not include all required components of a tagline, and CCHA Region 7 did not confirm monitoring mechanisms in place to ensure that ad hoc printing requests are printed and mailed to members within five business days. Additionally, CCHA Region 7 did not confirm a monitoring mechanism to ensure that members received a written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination.
- CCHA Region 7's documents did not include information about its website to meet all required member information components.
- CCHA Region 7's website contained a few minor errors on the FAQ webpage such as broken links to the Department's EPSDT information and some EPSDT informational details that included federal citations that were not member friendly.
- Submitted meeting minutes indicated some providers expressed concern when services for members were either not available or were denied and lower-level care was approved. Additionally, CCHA Region 7 submitted limited documentation to verify how EPSDT considerations are processed within the UM department, and the plan reported issues identifying this member population in two out of the four quarters in the review period, CY 2021.
- CCHA Region 7 did not outreach members who had not utilized EPSDT services in the previous 12 months during three of the four quarters in CY 2021. However, in the last quarter of CY 2021, CCHA Region 7 completed outreach to non-utilizers but noted an issue with data sorting procedures,

which lead to inadvertently outreaching members who had utilized services in the previous 12-month period.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Enhance procedures as well as create a care coordination workflow to better detail how CCHA Region 7 processes and prioritizes referrals and/or service denials (in which a member may need additional coordination) to ensure follow-ups when needed.
- Strengthen applicable care coordination documents and create a more detailed procedure that outlines PCMP referral procedures; timeliness expectations; and how CCHA Region 7 ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP tier, or condition management capabilities.
- Develop a mechanism to track and ensure timeliness of provider termination notices; revise critical member materials to include all required components of a tagline; develop a mechanism to ensure that, upon request, members are provided with printed materials within five business days; and communicate with the Department and CCHA Region 7 to ensure the updated welcome letter includes all required components, such as CCHA Region 7's website address.
- Ensure the accuracy and readability of website information prior to posting and reviewing links regularly as part of a best practice approach to maintaining EPSDT informational materials; expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process; develop a process to ensure access to foster care data so that corresponding outreach to newly eligible foster children is completed within 60 days of identification, either by DHS or CCHA Region 7; and continue annual EPSDT non-utilizer outreach procedures that were implemented at the end of CY 2021 and revisit QA procedures regarding the non-utilizer data set.

Validation of Network Adequacy

CCHA Region 7: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- While CCHA Region 7 did not meet all minimum time and distance network requirements across all counties in each county designation, Pediatric BH Practitioners had only one county in which it did not meet the standard and was less than 1 percent from meeting the standard.

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

HSAG found the following opportunities for improvement:

- CCHA Region 7 did not meet all minimum time and distance network requirements for all Adult, Family and Pediatric Primary Care Practitioners, Gynecology OB/GYN, SUD ASAM levels, and Psychiatric Hospitals across all contracted counties.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RAE 411 Over-Read

Table 3-78 presents CCHA Region 7's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-78—FY 2021–2022 Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 7

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	90.5%	97.1%
Principal Surgical Procedure Code	99.3%	NA	NA
Diagnosis Code	91.2%	97.1%	92.7%
Place of Service	NA	83.9%	83.2%
Service Category Modifier	NA	90.5%	97.1%
Units	NA	99.3%	95.6%
Revenue Code	97.8%	NA	NA
Discharge Status	57.7%	NA	NA
Service Start Date	97.8%	99.3%	98.5%
Service End Date	99.3%	99.3%	97.1%
Population	NA	99.3%	98.5%
Duration	NA	98.5%	97.1%
Staff Requirement	NA	98.5%	97.1%

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

Table 3-79 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 3-79—FY 2021–2022 BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 7

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	90.0%	100.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	100.0%	100.0%

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

CCHA Region 7: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- 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 was in 100 percent agreement with five out of six inpatient services data elements, and all 10 psychotherapy services and residential services data elements, respectively.

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

HSAG found the following opportunities for improvement:

- For the *discharge status* data element for inpatient services, CCHA Region 7's self-reported EDV results demonstrated a low level of encounter data accuracy at 57.7 percent when compared to the corresponding medical records.

To address the opportunities for improvement, HSAG recommends CCHA Region 7:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

CAHPS Survey

CCHA Region 7: Adult CAHPS

Table 3-80 shows the adult CAHPS results for CCHA Region 7 for FY 2021–2022.

Table 3-80—FY 2021–2022 Adult CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	49.4% ↓	55.2% ↓
Rating of All Health Care	49.2%+ ↓	56.5%
Rating of Personal Doctor	56.6% ↓ ▼	66.2%
Rating of Specialist Seen Most Often	71.7%+	69.2%
Getting Needed Care	80.9%+	80.9%
Getting Care Quickly	77.3%+	78.9%
How Well Doctors Communicate	92.7%+	91.3%
Customer Service	93.1%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

CCHA Region 7: Strengths

The following measures' FY 2021–2022 scores for CCHA Region 7 were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*

The following measures' FY 2021–2022 scores for CCHA Region 7 were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*

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

The following measures' FY 2021–2022 scores for CCHA Region 7 were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*

The following measure's FY 2021–2022 score for CCHA Region 7 was statistically significantly lower than the statewide average score for FY 2021–2022:

- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends CCHA Region 7:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including enhancing provider informational materials and exploring providers' ability to communicate effectively with members.

CCHA Region 7: Child CAHPS

Table 3-81 shows the child CAHPS results for CCHA Region 7 for FY 2021–2022.

Table 3-81—FY 2021–2022 Child CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2021–2022 Colorado RAE Aggregate
Rating of Health Plan	67.7%	70.8%
Rating of All Health Care	63.5% ↓	65.1% ↓
Rating of Personal Doctor	75.7%	76.1%
Rating of Specialist Seen Most Often	66.4%+	70.9%
Getting Needed Care	71.5%+ ↓	80.2% ↓
Getting Care Quickly	84.4%+	84.9%
How Well Doctors Communicate	93.7%	93.6%
Customer Service	86.4%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

CCHA Region 7: Strengths

The following measures' FY 2021–2022 scores for CCHA Region 7 were higher, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *How Well Doctors Communicate*
- *Customer Service*

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

The following measures' FY 2021–2022 scores for CCHA Region 7 were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*

The following measures' FY 2021–2022 scores for CCHA Region 7 were lower, although not statistically significantly, than the statewide average scores for FY 2021–2022:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*

To address these low CAHPS scores, HSAG recommends CCHA Region 7:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Quality Improvement Plan

Table 3-82 presents CCHA Region 7's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-82—Summary of CCHA Region 7 QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Psychotherapy	Procedure Code	86.9%	100%	100%	100%
	Diagnosis Code	89.8%	100%	100%	100%
	Service Category Modifier	86.9%	100%	100%	100%
Residential Services	Procedure Code	88.3%	100%	100%	100%
	Service Category Modifier	89.1%	100%	100%	100%
	Staff Requirement	79.6%	100%	100%	100%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

CCHA Region 7: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- All six encounter data types reached 100 percent accuracy by the first month of interventions and maintained the accuracy through the third month of the intervention period.
- CCHA Region 7 used a multifaceted approach in addressing low accuracy such as EHR software platform modifications, developing automated reports to identify records needing correction, reviewing the updated 411 Audit Guidelines document with providers, implementing a self-audit checklist, and conducting staff training on documentation requirements.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- CCHA Region 7 reported that the inaccuracies in baseline scores were mostly due to a lack of records submitted by providers for the audit, EHR limitations, and documentation not meeting minimum requirements.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-83 displays the MHP Audit compliance scores for CCHA Region 7 for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-83—FY 2021–2022 MHP Audit Score for CCHA Region 7

RAE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD Services					
CCHA Region 7	7	83%	Inpatient	78%	81%∨
			Outpatient	84%	

∨ *Indicates that the score declined as compared to the previous review year.*

CCHA Region 7: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- The inpatient and outpatient records reviewed for CCHA Region 7 demonstrated that it used nationally recognized UR criteria. CCHA Region 7 used MCG UR criteria for all MH UR determinations and ASAM level of care criteria for all SUD determinations.
- Annually, CCHA Region 7 required UM staff members to pass IRR testing with a minimum score of 90 percent.
- In most cases, CCHA Region 7 offered requesting providers a peer-to-peer review for medical necessity denials prior to a final determination.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- UR criteria used for the denial determination were not properly documented in one outpatient file.
- In multiple inpatient cases, CCHA Region 7 did not consistently follow policies and procedures regarding medical necessity review or referral.
- Within applicable records, the records did not contain documentation that provided evidence of implementing the State's processes or procedures for referring specific denials to care coordination.
- CCHA Region 7 did not consistently offer peer-to-peer review with the requesting provider prior to a final determination.
- CCHA Region 7 revised the NABD template following the FY 2020–2021 MHP audit findings; however, in several instances, the previous template was used. The previous template included several typographical errors, and reasons and rationales were often confusing and difficult to understand.
- The NABD was never sent to the member for several inpatient and outpatient records. Additionally, CCHA Region 7 sent NABDs to members for provider procedural issues, and CCHA Region 7 staff members were unaware that members should not receive these notices.
- CCHA Region 7 did not consistently follow stated procedures, which was reflected in the total score of 81 percent.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Enhance monitoring mechanisms to ensure UR criteria used for denial determinations are properly documented.
- Evaluate processes and develop trainings on policies and procedures regarding medical necessity review or referral.
- Develop training to ensure implementation of procedures regarding referrals to care coordination after a denial of service.
- Offer requesting providers peer-to-peer reviews prior to finalizing a denial determination for all cases involving a medical necessity review.
- Enhance monitoring mechanisms to ensure the correct NABD template is used and sent to the member within the required time frame.
- Provide training to ensure staff members are aware that members should not receive notices for provider procedural issues as interpretated in the BBA of 1997.
- Evaluate processes and develop training on procedures, Colorado-required processes, and the Medicaid managed care regulations to ensure the consistency of processes, documentation, and compliance with regulations.

Quality of Care Concern Audit

CCHA Region 7 used an internally developed definition for QOC issues. CCHA Region 7 submitted a *Quality-of-Care Procedure* for review and included the above definition. Additionally, CCHA Region 7 submitted a *Quality-of-Care Policy*; however, the policy did not include a definition. CCHA Region 7 had a total of 15 substantiated cases reported during the review period and used a six-level rating system to define the severity of QOC issues. CCHA Region 7's *Quality of Care Policy* defined the severity levels. Professionals with varying qualifications and/or degrees reviewed QOC issues submitted to CCHA Region 7.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, six were non-Hispanic White members.
- Four out of 10 members reported being disabled.
- Seven cases had level two severity and three had level three severity.
- Four out of 10 cases were related to a potentially harmful action to a member, three instances of treatment inconsistent with standards of practice, and two incorrect or inadequate medication issues.
- Two out of 10 case outcomes resulted in a CAP for the provider/facility.

CCHA Region 7 had a system for identifying and addressing all alleged QOC issues. When a concern was raised, CCHA Region 7 investigated, analyzed, tracked, trended, and resolved QOC issues

according to policy. CCHA Region 7 adhered to a CCHA Region 7 policy titled *Quality of Care Policy*. In addition to the policy, the RAE adhered to a procedure titled *Quality of Care Procedure*. The procedure provided direction for handling and reviewing QOC issues. Based on review of 10 sample cases and associated documents, HSAG determined that CCHA Region 7 adhered to its internal policies and procedures.

One of the 10 sample cases reviewed had an outcome reported to DORA. CCHA Region 7's policy stated that additional actions for QOC issues may include reporting to the relevant Colorado Department of Regulatory Agencies, Professions, and Occupations board.

CCHA Region 7: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7's QM department was responsible for investigating and developing an intervention, as necessary, to ensure quality and appropriateness of care is rendered to members. A *Quality of Care Procedure* described a process whereby QOC issues were reviewed from identification until resolution.
- The *Health First Colorado Member Handbook* and information on the RAE's website included information for the member about the process for reporting a grievance. For the members' ease of understanding, the member materials did not distinguish the difference between a grievance and a QOCG.
- The provider manual included information about critical incident reporting and management and QOC. The information provided steps for reporting and a link to the form. Additionally, a link to the form was on CCHA Region 7's website. Within the CCHA Region 7 provider manual, providers were reminded that they must cooperate with any investigation conducted by CCHA Region 7 or an outside agency.
- CCHA Region 7 had letter and form templates that were clear and concise. Letters outlined the entire investigation and resolution findings in an easy to read format.
- As needed, and according to policy, CCHA Region 7 reviewed QOC issues with the following:
  - Peer Review Committee
  - Compliance department
  - CCHA Region 7's legal department
  - Credentialing Committee
- For the case samples reviewed that had a CAP initiated, CCHA Region 7 requested that the provider/facility submit supporting documentation related to the CAP. Additionally, CCHA Region 7 provided a CAP template within the letter. This process prompts the facility/provider to complete a thorough and meaningful plan and, partnered with CCHA Region 7 requesting

evidence of the plan, should be considered a best practice of CCHA Region 7. Case samples reviewed provided evidence that CCHA Region 7 is requesting documentation based on the CAP developed.

- CCHA Region 7 provided evidence of a quarterly *Fiscal Year 2021–2022 Quality of Care Summary* that was sent to the Department. The report included a summary of referrals for the quarter, rolling 12-month data, and quarterly data for severity levels and types of QOC issues. Additionally, the report contained information on high volume providers and specific details for cases above a level three severity, along with the QM department's ongoing efforts. CCHA Region 7 staff members stated that if the Department would request additional information about a particular case, they would follow the RAE's contractual requirements.
- CCHA Region 7 staff members stated that an annual training for QOC issues, grievances, and appeals was provided and the RAE's goal is for staff members to feel comfortable reporting any issue. During the training, the QOC issue reporting process was reviewed. CCHA Region 7 provided evidence of the training that was held on January 24 and 25, 2022.
- In an effort to lessen provider burden, CCHA Region 7 will accept any form of critical or QOC issue reporting. Meaning, the provider is not required to use CCHA Region 7's form to report. However, CCHA Region 7 has made the form accessible for providers and ensures all information is captured about the potential incident.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

- During the interview, CCHA Region 7 staff members described the process for following up with the member to determine if immediate healthcare needs are being met and stated that the safety of the member is priority to CCHA Region 7. CCHA Region 7 staff members stated that care coordinators may outreach the member and follow up. However, this process was not described in policy or procedure.
- CCHA Region 7 staff members reported that the QM department and grievance team work in tandem if the QOC issue is reported by a member/member advocate. However, neither CCHA Region 7's policy nor procedure outlined a process to ensure acknowledgement and resolutions are distributed to the member/member advocate. Possible gaps between the QM department and grievance team could exist if the QM department entrusts the grievance team with this step and is not following up or capturing dates or other evidence that letters were distributed.
- At the time of this audit, CCHA Region 7 did not have timelines or time frames for the QOC investigation start to finish process outlined in policy or procedure. Additionally, CCHA Region 7 staff members stated they have not been tracking the process in order to identify a time frame. CCHA Region 7's procedure identified some specific timelines for egregious cases, in which the

medical record request would be made within 72 hours (three business days) after receipt of the QOC issue, and the medical director has 72 hours (three business days) to make a determination. In all other cases, the medical director has 10 business days from the time of receipt to review the case and determine an outcome. Urgent cases must be reviewed within 72 hours (three business days) from the time of the referral. If a case has a preliminary severity level of five, the medical director will be scheduled for an emergency meeting of the QMC and will follow the peer review process within five calendar days of the assigned severity level. CCHA Region 7 staff members reported that providers not submitting medical records and/or additional information related to the case is a barrier to securing the records; providers are reluctant to submit records because they question CCHA Region 7's validity of the request due to CCHA Region 7 not being the payor of the claim. CCHA Region 7's policy stated that CCHA Region 7 will resolve QOC issues within a timely manner, taking into consideration the clinical urgency of the situation. 

- CCHA Region 7 staff members requested that a better, more efficient process for trending, tracking, and uploading information to the Department be considered for the QOC issue process. Also, CCHA Region 7 is hoping a communication process is developed that notifies all RAEs if a systemic issue is identified amongst the facility and/or provider network. 

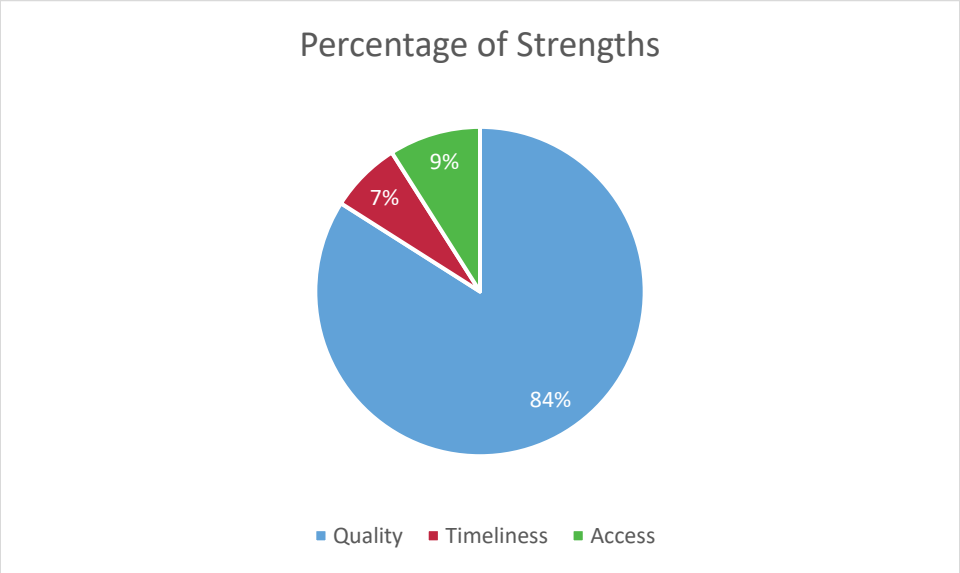
To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Continue conducting staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:
  - Incorporate contract requirements.
  - Incorporate the process for reporting to the Department.
  - Establish a time frame and/or goals for the QOCG process.
- Continue requesting evidence of the CAP from a facility/provider when a CAP is initiated.
- Continue notifying the Department of QOC issues received and continue reaching out to the Department to report ad hoc cases of severity, systematic concerns, and termination of any network provider.
- Have its QM department continue to work in tandem with the grievance department to send out acknowledgment and resolution letters to members/member advocates. Additionally, CCHA Region 7 could implement a process for capturing dates or information from the letters that the grievance team distributes. This process will provide the QM department the verification that both acknowledgment and resolution letters were provided to the member/member advocate.

Managed Care Organizations

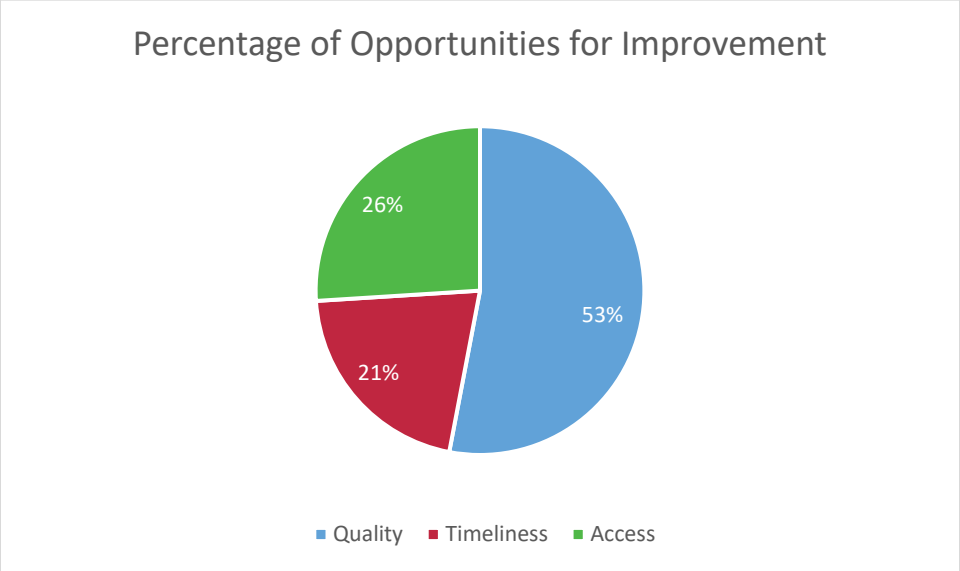
Denver Health Medical Plan

Figure 3-15—Percentage of Strengths by Care Domain for DHMP*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-16—Percentage of Opportunities for Improvement by Care Domain for DHMP*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are DHMP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of DHMP's Performance Improvement Project

Validation Activities and Interventions

In FY 2021–2022, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, DHMP established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-84 and Table 3-85 summarize DHMP's PIP activities that were completed and validated in FY 2020–2021. Table 3-84 provides the SMART Aim statements that DHMP defined for the two PIP outcome measures in Module 1.

Table 3-84—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for DHMP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 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, from 65.86% to 68.86%.
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 completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics from 47.89% to 58.89%.

**The SMART Aim statement was revised in June 2021. HSAG approved revisions to the SMART Aim statement in June 2021 in response to DHMP's correction of data queries used to produce the baseline percentage and goal.*

Table 3-85 summarizes the preliminary key drivers and potential interventions DHMP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-85—Preliminary Key Drivers and Potential Interventions 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 BH follow-up services in EMR and data systems. • Adequate appointment length to address positive depression screen. • Attendance of scheduled BH 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 BH provider following positive depression screen.

FY 2021–2022 PIP Activities

In FY 2021–2022, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, DHMP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, DHMP submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as DHMP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-86 presents the FY 2021–2022 Module 3 validation findings for DHMP's two interventions.

Table 3-86—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Expand depression screening services to all primary care acute (sick) visits in addition to well visits	Member declines well visit	Member attends a visit annually (when depression screening services would typically be provided)	The percentage of acute visits attended by adolescent members during which a depression screening was completed and documented in Epic
Same-day warm handoff to in-clinic BH provider when a member screens positive for depression	Member does not attend follow-up BH appointment	Member attends BH follow-up visit after a positive depression screen	The percentage of adolescent members who screen positive for depression and receive a same-day BH visit or have a follow-up plan documented in the EHR stating that the member is already engaged in BH services

In Module 3, DHMP selected two interventions to test for the PIP. The interventions addressed process failures related to appointment attendance and access to services. For each intervention, DHMP defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, DHMP continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- Selected two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. DHMP addressed all Module 3 PIP validation criteria.

To support successful progression of DHMP's PIP in the next fiscal year, HSAG recommends:

- DHMP collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- DHMP ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, DHMP should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, DHMP should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

HEDIS Measure Rates and Validation

DHMP: Information Systems Standards Review

According to the HEDIS MY 2021 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 performance measure reporting.

DHMP: Performance Measure Results

Table 3-87 shows the performance measure results for DHMP for MY 2019 through MY 2021, along with the percentile ranking for each MY 2021 rate, if available. Rates for MY 2021 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2021 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Table 3-87—Performance Measure Results for DHMP

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
Ages 50 to 64 Years[SA]	—	—	41.70%	ASA
Ages 65 to 74 Years[SA]	—	—	30.96%	BSA
Cervical Cancer Screening				
Cervical Cancer Screening[H]	45.58%	41.11%	39.36%	<10th
Child and Adolescent Well-Care Visits				
Total[H]	—	39.31%	41.93%	25th–49th
Childhood Immunization Status				
Combination 3[H]	66.67%	67.98%	**61.92%^^**	10th–24th
Combination 7[H]	57.63%	57.81%	**53.08%^^**	10th–24th
Combination 10[H]	42.85%	40.18%	40.22%	50th–74th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	72.63%	67.65%	76.77%^	≥90th
Ages 21 to 24 Years[H]	73.29%	66.95%	68.54%	75th–89th
Developmental Screening in the First Three Years of Life				
Total[CS]	—	—	—	—
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)[H]	78.06%	75.70%	**64.92%^^**	<10th
Combination 2 (Meningococcal, Tdap, HPV)[H]	50.47%	45.11%	**35.93%^^**	25th–49th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[SA]	—	—	—	—
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile Documentation—Total[H]	25.11%	65.36%	70.33%^	25th–49th
Counseling for Nutrition—Total[H]	9.16%	69.85%	74.36%^	50th–74th
Counseling for Physical Activity—Total[H]	8.08%	69.19%	73.75%^	75th–89th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	—	54.69%	54.34%	25th–49th
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits[H]	—	57.13%	54.42%	<10th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age				
Total[SA]	—	—	—	—
Contraceptive Care—All Women				
LARC—Ages 15 to 20 Years[CS]	—	—	—	—
LARC—Ages 21 to 44 Years[CS]	—	—	—	—
MMEC—Ages 15 to 20 Years[CS]	—	—	—	—
MMEC—Ages 21 to 44 Years[CS]	—	—	—	—
Contraceptive Care—Postpartum Women				
LARC—3 Days—Ages 15 to 20 Years[CS]	—	—	—	—
LARC—3 Days—Ages 21 to 44 Years[CS]	—	—	—	—
LARC—60 Days—Ages 15 to 20 Years[CS]	—	—	—	—
LARC—60 Days—Ages 21 to 44 Years[CS]	—	—	—	—
MMEC—3 Days—Ages 15 to 20 Years[CS]	—	—	—	—
MMEC—3 Days—Ages 21 to 44 Years[CS]	—	—	—	—
MMEC—60 Days—Ages 15 to 20 Years[CS]	—	—	—	—
MMEC—60 Days—Ages 21 to 44 Years[CS]	—	—	—	—
Elective Delivery				
Ages 18 to 64 Years[SA]	—	—	—	—
Prenatal and Postpartum Care				
Postpartum Care[H]	66.50%	69.22%	70.66%	10th–24th
Timeliness of Prenatal Care[H]	84.53%	83.36%	**79.51%^^**	25th–49th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Care of Acute and Chronic Conditions				
Asthma in Younger Adults Admission Rate*				
Ages 18 to 39 Years[CS]	—	—	—	—
Asthma Medication Ratio				
Total (Ages 5 to 18 Years)[CS]	—	—	59.89%	BCSM
Total (Ages 19 to 64 Years)[CS]	—	—	47.38%	BCSM
COPD or Asthma in Older Adults Admission Rate*				
Ages 40 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 to 75 Years[SA]	—	—	—	—
Controlling High Blood Pressure				
Ages 18 to 64 Years[SA]	—	—	48.54%	ASA
Ages 65 to 85 Years[SA]	—	—	55.92%	ASA
Diabetes Short-Term Complications Admission Rate*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Heart Failure Admission Rate*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
HIV Viral Load Suppression				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	—	—	47.54%	10th–24th
Antidepressant Medication Management				
Effective Acute Phase Treatment—Ages 18 to 64 Years[SA]	—	—	64.50%	ASA
Effective Acute Phase Treatment—Ages 65 Years and Older[SA]	—	—	78.00%	ASA
Effective Continuation Phase Treatment—Ages 18 to 64 Years[SA]	—	—	42.55%	ASA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Effective Continuation Phase Treatment—Ages 65 Years and Older[SA]	—	—	72.00%	ASA
Concurrent Use of Opioids and Benzodiazepines*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%)*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 to 75 Years[SA]	—	—	—	—
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[H]	—	—	86.68%	≥90th
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Ages 18 to 64 Years[SA]	—	—	15.29%	ASA
7-Day Follow-Up—Ages 65 Years and Older[SA]	—	—	2.08%	ASA
30-Day Follow-Up—Ages 18 to 64 Years[SA]	—	—	21.09%	ASA
30-Day Follow-Up—Ages 65 Years and Older[SA]	—	—	6.25%	ASA
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	21.44%	10th–24th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	29.02%	<10th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	—	NA
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	8.54%	<10th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	—	NA
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	15.85%	<10th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	41.35%	41.28%	30.95%	<10th
Continuation and Maintenance Phase[H]	—	—	—	NA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	41.07%	ASA
Initiation of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	61.05%	ASA
Initiation of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	54.55%	ASA
Initiation of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Initiation of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	40.41%	ASA
Initiation of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	51.52%	ASA
Initiation of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	42.20%	ASA
Initiation of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	61.38%	ASA
Engagement of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	6.32%	ASA
Engagement of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	6.32%	ASA
Engagement of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	14.02%	ASA
Engagement of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Engagement of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	3.67%	ASA
Engagement of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	3.03%	ASA
Engagement of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	6.40%	ASA
Engagement of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	6.90%	ASA
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[H]	—	50.00%	—	NA
Cholesterol Testing—Total[H]	—	47.22%	—	NA
Blood Glucose and Cholesterol Testing—Total[H]	—	36.11%	—	NA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total[H]	—	—	—	NA
Use of Opioids at High Dosage in Persons Without Cancer*				
Ages 18 to 64 Years[SA]	—	—	—	—
Ages 65 Years and Older[SA]	—	—	—	—
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	—	—	—	—
Rate 2: Buprenorphine[SA]	—	—	—	—
Rate 3: Oral Naltrexone[SA]	—	—	—	—
Rate 4: Long-Acting Injectable Naltrexone[SA]	—	—	—	—
Rate 5: Methadone[SA]	—	—	—	—
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	22.47	NA
Plan All-Cause Readmissions				
Observed Readmissions—Total[H]	13.79%	11.35%	9.51%	25th–49th
Expected Readmissions—Total[H]	—	—	9.63%	25th–49th
*O/E Ratio—Total**[H]	1.26	1.14	0.99	50th–74th

**For this indicator, a lower rate indicates better performance.*
H indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
CS indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
SA indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
BSA indicates the reported rate was below the statewide average.
ASA indicates the reported rate was above the statewide average.
BCSM indicates the reported rate was below the Core Set Median.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

DHMP: Strengths

The following MY 2021 HEDIS 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 MY 2020, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2020):

- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Ages 21 to 24 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

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

The following MY 2021 HEDIS 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 MY 2020):

- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Ages 18 to 64 Years* and *30-Day Follow-Up—Ages 18 to 64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64 Years* and *30-Day Follow-Up—Ages 18 to 64 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be low-performing rates for DHMP (i.e., fell below the Core Set Median):

- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)* and *Total (Ages 19 to 64 Years)*

To address these low rates, HSAG recommends DHMP:

- Work with the Department and providers to identify the causes for low access to care and preventive screening.
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccination.[3-1]
- Promote well-care visits with providers as an opportunity for providers to influence health and development, and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-2]

Assessment of Compliance With Medicaid Managed Care Regulations

DHMP Overall Evaluation

Table 3-88 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 2021–2022.

Table 3-88—Summary of DHMP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)*
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	18	14	4	0	0	78%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

[3-1] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 21, 2022.

[3-2] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 21, 2022.

DHMP: Trended Performance for Compliance With Regulations

Table 3-89—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, 2021–2022)	**70%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2018–2019, 2021–2022)	**82%**	**78%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2019–2020)	86%	83%
Standard VII—Provider 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, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2020–2021)	88%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019, 2021–2022)	**86%**	**100%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*

In FY 2021–2022, DHMP demonstrated consistent high-achieving scores or improvement from the previous review year for three of the four standards reviewed: Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. However, Standard V—Member Information Requirements declined by 4 percentage points compared to the previous review.

DHMP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for DHMP:

- DHMP informed members how to contact their primary healthcare providers through welcome materials, and members enrolled in one of DHMP's 17 care management programs received a welcome letter with additional contact information.
- DHMP communicated member rights through various channels such as the member handbook, provider manual, new provider orientation, provider and member newsletters, website, the grievance system, the *Notice of Privacy Practices*, and evidence of coverage information.
- DHMP had policies, procedures, and processes to describe objectives and goals for the organization to foster a culturally sensitive workplace. DHMP assessed bilingual staff to test for fluency levels. Additionally, staff members were required to complete trainings related to cultural diversity and the use of interpreter services.
- DHMP utilized a combination of approaches to onboard and inform members about EPSDT services within the first 60 days after eligibility determination. Staff members described multiple methods to outreach members annually if a member had not utilized EPSDT services. These reminders occurred in the form of annual birthday fliers, the member portal, care management outreach, and direct provider outreach.

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

HSAG found the following opportunities for improvement:

- Some critical member materials did not include all the required components of a tagline, including some 2021 member newsletters; taglines were on the last page of these newsletters instead of more prominent locations; and some critical member materials were above the sixth-grade reading level.
- In DHMP's Medicaid Choice member handbook, the "grievance" definition was inconsistent with the State and the federal definition. DHMP defined a grievance as a "formal complaint" instead of "any expression of dissatisfaction." Additionally, DHMP did not provide additional supporting documentation regarding monitoring the five-business-day turnaround time for ad hoc requests for printed materials.

To address these opportunities for improvement, HSAG recommends DHMP:

- Revise critical member materials to include all required components of a tagline and include the taglines in prominent locations; develop mechanisms to ensure that all required member

informational materials may be easily understood (i.e., sixth-grade reading level) to the extent possible; and use simplified language next to any clinical terminology DHMP does not wish to alter.

- Update the definition of "grievance" in the Medicaid Choice member handbook to be consistent with the State and federal definition, and develop a mechanism to ensure that ad hoc printing requests are provided and mailed to the member within five business days.

Validation of Network Adequacy

DHMP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- While DHMP did not meet all minimum time and distance network requirements across all counties in each county designation, Adult, Family and Pediatric Primary Care Practitioners (MD, DO, NP, CNS) and General BH Practitioners had only one county in which they did not meet the standard and were less than 1 percent from meeting the standard.
- 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

HSAG found the following opportunities for improvement:

- DHMP did not meet all minimum time and distance requirements for General SUD Treatment Practitioners, all SUD treatment facilities contracted at different ASAM levels of care, Acute Care Hospitals, General and Pediatric Specialties, and Pharmacies across all contracted counties.

To address these opportunities for improvement, HSAG recommends DHMP:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—DHMP 411 Audit Over-Read

Table 3-90 presents DHMP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-90—FY 2021–2022 Self-Reported EDV Results by Data Element and BH Service Category for DHMP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	75.9%	97.1%
Principal Surgical Procedure Code	97.1%	NA	NA
Diagnosis Code	85.4%	89.1%	95.6%
Place of Service	NA	73.0%	97.8%
Service Category Modifier	NA	75.9%	97.8%
Units	NA	94.2%	97.8%
Revenue Code	96.4%	NA	NA
Discharge Status	92.0%	NA	NA
Service Start Date	94.9%	97.8%	97.8%
Service End Date	97.1%	97.8%	97.8%
Population	NA	95.6%	97.8%
Duration	NA	86.9%	97.8%
Staff Requirement	NA	86.1%	97.8%

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

Table 3-91 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with DHMP's EDV results for each of the validated data elements.

Table 3-91—FY 2021–2022 BH EDV Over-Read Agreement Results by BH Service Category for DHMP

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Principal Surgical Procedure Code	100.0%	NA	NA
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	90.0%	100.0%
Service Category Modifier	NA	90.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	90.0%	100.0%
Service End Date	100.0%	90.0%	100.0%
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	100.0%	100.0%

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

DHMP: Strengths

Based on RAE 411 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- HSAG's over-read findings suggest a high level of confidence that DHMP's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with all six inpatient services data elements, six of the 10 psychotherapy services data elements, and all 10 residential services data elements.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to DHMP's 411 Audit Over-Read

HSAG found the following opportunities for improvement:

- DHMP's self-reported EDV results demonstrated only a moderate level of accuracy within the psychotherapy services category, including 75.9 percent accuracy for the *procedure code* and *service category modifier* data elements and a 73.0 percent accuracy for the *place of service* data element.

To address the opportunities for improvement, HSAG recommends DHMP:

- Consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Encounter Data Validation—DHMP 412 Audit Over-Read

FY 2021–2022 was DHMP's seventh year participating in the independent MCO EDV and subsequent over-read. DHMP validated 103 cases from each of four service categories. Table 3-92 presents DHMP's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-92—FY 2021–2022 Self-Reported EDV Results by Data Element and Service Category for DHMP

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	100%	98.1%	96.1%	100%
Through Date	99.0%	NA	NA	NA
Diagnosis Code	95.1%	86.4%	76.7%	88.4%
Surgical Procedure Code	98.0%	NA	NA	NA
Procedure Code	NA	89.3%	77.7%	80.6%
Procedure Code Modifier	NA	97.1%	97.1%	95.1%
Discharge Status	95.1%	NA	NA	NA
Units	NA	96.1%	96.1%	100%

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

Table 3-93 presents DHMP's FY 2021–2022 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 the same as the overall agreement rate from the FY 2020–2021 EDV study.

Table 3-93—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for DHMP

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	95.0%	120	98.3%
Outpatient	20	85.0%	100	95.0%
Professional	20	100.0%	100	100.0%
FQHC	20	85.0%	100	93.0%
Total	**80**	**91.3%**	**420**	**96.7%**

DHMP: Strengths

Based on MCO 412 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- Results from HSAG's over-read suggest a high level of confidence that DHMP's independent validation findings accurately reflect the encounter data quality summarized in DHMP's service coding accuracy results.
- Overall, the FY 2021–2022 results indicate complete case-level agreement with DHMP's internal validation results for 91.3 percent of cases and an element-level agreement rate of 96.7 percent.
- HSAG's review of the study documentation provided by the Department and DHMP suggests that all parties followed the guidelines while conducting the EDV.

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

HSAG found the following opportunities for improvement:

- DHMP's service coding accuracy results indicate that greater than 20.0 percent of the sampled professional cases had diagnosis or procedure codes that were not supported by medical record documentation.
- Among the professional cases, two of the accuracy rates were below 80.0 percent (*diagnosis code*, 76.7 percent and *procedure code*, 77.7 percent).

To address the opportunities for improvement, HSAG recommends DHMP:

- Consider internal data monitoring and provider training to improve medical record documentation.

CAHPS Survey

Table 3-94 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2019–2020 through FY 2021–2022.

Table 3-94—Adult Medicaid Top-Box Scores for DHMP

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	60.3%	58.0%	58.6%
Rating of All Health Care	55.5%	58.1%	52.8%
Rating of Personal Doctor	69.6%	77.7%	68.9% ▼
Rating of Specialist Seen Most Often	74.1%+	63.2%	70.6%
Getting Needed Care	74.5%	84.1%	71.7% ↓ ▼
Getting Care Quickly	73.5%	79.9%	71.3% ↓
How Well Doctors Communicate	94.2%	94.2%	92.1%
Customer Service	89.1%+	91.5%	87.9%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

DHMP: Adult Medicaid Strengths

The following measure's FY 2021–2022 score for DHMP was higher, although not statistically significantly, than the 2021 NCQA national average:

- *Rating of Specialist Seen Most Often*

The following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly, than the FY 2020–2021 scores:

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

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

The following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the 2021 NCQA national averages:

- *Getting Needed Care*

- *Getting Care Quickly*

The following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the FY 2020–2021 scores:

- *Rating of Personal Doctor*
- *Getting Needed Care*

To address these low CAHPS scores, HSAG recommends DHMP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the timeliness of and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Table 3-95 shows the child Medicaid CAHPS results achieved by DHMP for FY 2019–2020 through FY 2021–2022.

Table 3-95—Child Medicaid Top-Box Scores for DHMP

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	67.4%	68.4%	72.3%
Rating of All Health Care	66.0%+	76.5%+	70.7%+
Rating of Personal Doctor	78.8%	80.6%	82.3%
Rating of Specialist Seen Most Often	60.9%+	80.8%+	87.5%+
Getting Needed Care	75.1%+	84.8%+	80.2%+
Getting Care Quickly	80.5%+	89.0%+	82.1%+
How Well Doctors Communicate	94.9%+	96.3%+	93.7%+
Customer Service	89.0%+	91.3%+	89.6%+

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

↑ *Indicates the FY 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

DHMP: Child Medicaid Strengths

For the child population, the following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Health Plan*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Customer Service*
- *Coordination of Care*

For the child population, the following measures' FY 2021–2022 scores for DHMP were higher, although not statistically significantly, than the FY 2020–2021 scores:

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

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

For the child population, the following measures' FY 2021–2022 scores for DHMP were lower, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

For the child population, the following measures' FY 2021–2022 scores for DHMP were lower, although not statistically significantly, than the FY 2020–2021 scores:

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

To address these low CAHPS scores, HSAG recommends DHMP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.

Quality Improvement Plan

Table 3-96 presents DHMP's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-96—Summary of DHMP QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Outpatient	Procedure Code	87%	100%	100%	100%
Professional	Date of Service	87%	33%	53%	68%
	Diagnosis Code	69%	3%	47%	47%
	Procedure Code	79%	20%	47%	68%
	Procedure Code Modifier	79%	33%	47%	68%
	Units	85%	3%	53%	68%
FQHC	Diagnosis Code	85%	90%	100%	90%
	Procedure Code	77%	90%	60%	60%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

DHMP: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- DHMP reported an improved accuracy score of 100 percent for the outpatient *procedure code* encounter data type in all three months post intervention.

- Within the FQHC claim type, *diagnosis code* encounter data type accuracy increased from 85 to 90 percent in month one, increased to 100 percent in month two, then decreased to 90 percent again in month three, resulting in a 5 percentage point increase over baseline.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- Overall, DHMP experienced notable decreases in accuracy rates within the professional and FQHC claim types.
- DHMP's interventions had a low to moderate likelihood of improving outcomes based on a variance in scores over the three-month intervention period and overall low accuracy rates at the end of the QUIP project.
- For the professional claim type, DHMP reported that the pilot providers did not all submit records; this had an impact on the overall results, which remained below 90 percent accuracy at the end of the intervention.

To address these opportunities for improvement, HSAG recommends DHMP:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-97 displays the MHP Audit compliance scores for DHMP for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-97—FY 2021–2022 MHP Audit Score for DHMP

MCO	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD and M/S Services				
DHMP	100%	Inpatient	99%	97%∨
		Outpatient	96%	

∨ *Indicates that the score declined as compared to the previous review year.*

DHMP: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- DHMP delegated UM for BH services to COA and followed policies and procedures regarding adequate monitoring and oversight of the delegated UM activities.
- DHMP demonstrated that COA used nationally recognized UR criteria, including InterQual UR criteria, for MH determinations and ASAM level of care criteria for SUD determinations.
- UM staff members were required to pass IRR testing annually with a minimum score of 90 percent.
- Policies and procedures were followed related to which services require prior authorization and providing notices to the member and the provider.
- NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all required information. Additionally, most NABDs were provided to the members within the required time frame.
- In all cases involving a medical necessity review, COA offered requesting providers peer-to-peer reviews prior to finalizing a denial determination.
- DHMP demonstrated several best practices through COA's processes related to implementing the new SUD benefits.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- One outpatient file requesting out-of-network BH services was sent to DHMP and never forwarded to COA for determination. Additionally, DHMP did not follow COA's processes for medical necessity review of out-of-network requests.
- An NABD was not sent within the 72-hour time frame for one inpatient expediated determination.
- COA did not include the specific name of the criteria (InterQual, ASAM, etc.) used within the NABD.

To address these opportunities for improvement, HSAG recommends DHMP:

- Provide training to DHMP UM staff members periodically to ensure BH requests are routed to COA.
- Ensure all NABDs are sent within the required time frame, and if the determination occurs during a weekend or holiday, the determination is referred to the proper personnel.
- Include within the NABD the specific name of the criteria used to make the denial determination. Additionally, DHMP and COA must collaborate to determine if DHMP letterhead should be used of if the letter should explain the delegation to COA to avoid confusion for the member.

Quality of Care Concern Audit

DHMP provides services for PH primary, inpatient, outpatient, specialty, and acute care for a subset of Region 5 RAE members and behavioral inpatient and outpatient services for a subset of Region 5 RAE members. DHMP investigates any QOC complaint that is related to a member's PH and subcontracts with COA to investigate any QOC complaint related to a member's BH services.

For PH, DHMP used an internally developed definition for QOC complaints. DHMP submitted a policy titled *Notification and Investigation of Quality-of-Care Complaints* for review. The definition was stated in policy. DHMP did not report any substantiated PH QOC complaints during CY 2021. DHMP's policy described a findings determination for QOC complaints. Definitions for each finding were stated in DHMP's *Notification and Investigation of Quality-of-Care Complaints* policy. Professionals with varying qualifications and/or degrees reviewed QOC complaints submitted to DHMP.

DHMP reported no PH QOC complaints during the review period; therefore, case samples could not be reviewed for this activity.

DHMP's policy described its process for investigating, analyzing, tracking, trending, and resolving QOC complaints when a PH concern is raised. HSAG was unable to determine if DHMP adhered to its internal policies and procedures for handling PH QOC complaints.

DHMP reported no PH QOC complaints during the review period; therefore, case samples could not be reviewed for whether the CAP was followed and monitored until completion. Neither DHMP's policy nor desk procedure described a process for CAP reporting and monitoring.

DHMP reported no PH QOC complaints during the review period; therefore, case samples could not be reviewed for regulatory agency reporting. DHMP's policy stated that a QOC complaint can be reported to the appropriate regulatory agency and child or adult protective services for further research, review, or action, when appropriate.

For BH, DHMP's delegated entity (COA) used an internally developed definition for QOCC. DHMP submitted a *Quality-of-Care Concern* desk procedure along with a *Quality-of-Care Concern Investigation Policy and Procedure* for review from COA. The definition stated in policy is similar. DHMP had four BH-related QOCC cases; therefore, COA conducted the review. DHMP did not report any PH-substantiated QOCC cases during CY 2021. During the review period, COA reviewed BH QOC concerns and used a four-level rating system to define the severity of QOC concerns. COA's policy did not define the severity levels; however, a *Quality-of-Care Concern* desk procedure submitted for review defined each severity level. Professionals with varying qualifications and/or degrees reviewed QOCC submitted to DHMP.

The following trends were identified within the sample cases reviewed:

- None of the members from the four sample cases were Hispanic or Latino.
- Two out of four members were disabled.
- Three cases had level two severity and one case was a level one.
- All four cases were related to lack of follow-up/discharge planning.
- Two out of four case outcomes resulted in a CAP for the provider/facility.
- COA had a system for identifying and addressing all alleged QOC concerns. When a concern was raised, the entity investigated, analyzed, tracked, trended, and resolved QOC concerns according to policy. COA adhered to a COA policy titled *Quality-of-Care Concern Investigation Policy and Procedure*. In addition to the policy, the entity adhered to a *Quality-of-Care Concern* desk procedure, which provided direction for handling and reviewing QOC concerns. Based on review of four sample cases and associated documents, HSAG determined that COA adhered to its internal policies and procedures.
- None of the four sample cases reviewed had outcomes reported to a regulatory agency or licensing board. COA's policy stated that the QM department will report to the chief compliance officer any issues that may need to be reported to an appropriate regulatory agency or state licensing board and child or adult protective services for further research, review, or action.

DHMP: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP (PH):

- DHMP's policy described the process for handling QOC complaints. The grievance and appeals manager was responsible for the administration and oversight of this process.
- The *Health First Colorado Member Handbook* and information on the MCE's website included information for the member about the process for reporting a grievance. For the members' ease of understanding, the member materials did not distinguish the difference between a grievance and a QOCG.
- The provider manual included a definition of a QOC complaint. The manual stated that during recredentialing, the credentialing department would verify with the UM department if there have been any QOC concerns in the past three years for each practitioner going through the recredentialing process. Providers were instructed to follow the grievance process for reporting a QOC complaint.
- DHMP accepted QOC complaints orally or in writing at any time, with no time limit to file/report. DHMP used criteria to establish a potential QOC complaint. QOC complaints included, but were not limited to, jeopardizing the health, safety, or welfare of members; and/or violating the company policies and procedures related to member care.
- DHMP had letter templates developed for medical record requests, acknowledgment, resolution, and extensions that were clear and concise.
- DHMP had developed a QOC complaints training for the grievance and appeal team. The training provided a definition, how complaints are received, and the process for handling QOC complaints.

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP (BH):

- COA's QM department investigated and resolved concerns directly related to the quality of the medical care or BH care of a member. Policies described a process whereby the QM department, with oversight by a medical director or physician designee, would investigate, analyze, track, trend, and resolve QOC concerns.
- The *Health First Colorado Member Handbook* and information on the MCE's website included information for the member about the process for reporting a grievance. Members were instructed to speak with their provider, the MCE, and/or Ombudsman. The member materials did not distinguish the difference between a grievance and a QOCG.
- If a grievance was clinical care-based and believed to meet the qualifications of a QOC concern, the grievance team would send the grievance to the QM department to confirm the concern meets the

threshold of a QOC concern. The grievance could also be split between the QM department and grievance department if only parts of the complaint meet the threshold of a QOC concern.

- The provider manual included definitions of a QOC concern and critical incident. The manual also included information for reporting potential QOC concerns and critical incidents and that reporting a potential concern or incident is confidential. COA provided evidence of a provider newsletter that was sent via email to all providers on December 9, 2021. The newsletter provided information about a new form that should be utilized for reporting concerns and/or incidents. The *Quality of Care and Critical Incident Notification* form was linked on COA's website and could be emailed to the QOC email inbox at COA.
- COA had letter and form templates that were clear and concise. Additionally, if a CAP needed to be developed, a helpful tips guide for developing a CAP was given to the provider/facility, along with a CAP template. Acknowledgment and resolution notification were sent to the individual who reported/initiated, which may or may not be internal COA staff.
- Throughout the sample case review and interview discussion, COA demonstrated a collaborative approach with facilities and/or providers if an intervention or CAP was needed. COA provided an education letter and/or conducted one-on-one meetings with providers to guide them through the CAP. COA staff members stated they would continue to monitor the facility/provider to ensure the QOC concern volume decreases as a means of monitoring the effectiveness of the intervention or CAP.
- As needed, and according to policy, COA reviewed QOC concerns with the following:
  - External professional review (peer review)
  - Compliance department
  - COA's legal department
  - Credentialing Committee
- COA's policy included information for monitoring trends that emerge from QOC concern notifications. Staff members reported that the QM department trends information on an ongoing basis and reports the occurrence of QOC concerns annually in the quality report, which is ultimately reported to the Department. Additionally, COA reported to the Department if the Department requested or if a severe or systemic concern was identified. One sample case reviewed had been referred to COA by the Department. The QOC concern was investigated by COA and reported to the Department according to contractual requirements.
- COA staff members stated that care managers and UM coordinators participate in a QOC concern training. Additionally, COA staff members reported that an increase in volume of QOC concerns was noted after the training; however, this increase was expected.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOCC Audit

HSAG found the following opportunities for improvement:

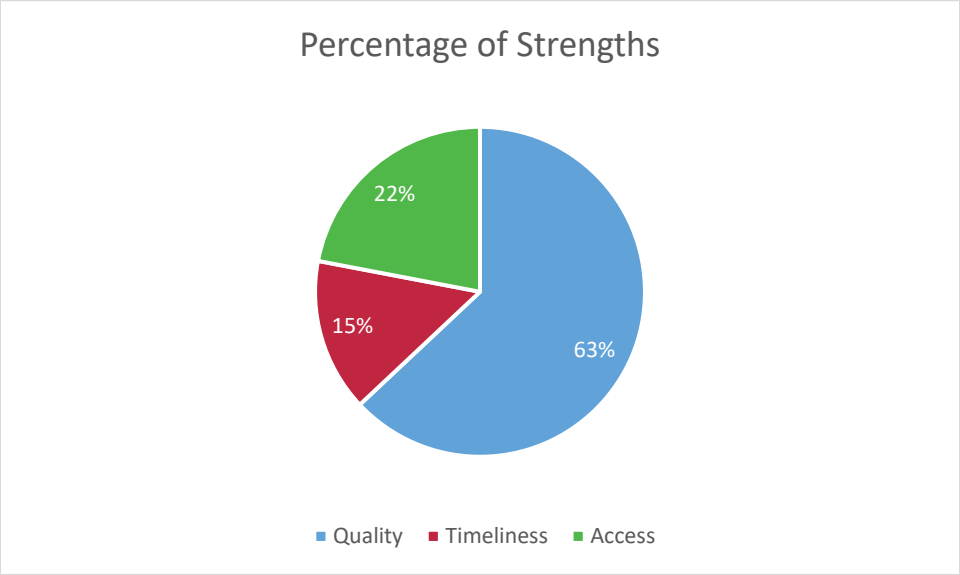
- COA staff members reported that the QM team and grievance team work in tandem if the QOC concern is reported by a member/member advocate. However, possible gaps could exist if the QM team investigates the QOC concern but the grievance team sends the acknowledgment and resolution letters. For the QOC concern tracking, the QM team did not capture dates or other evidence that these letters were sent by the grievance team. 
- At the time of this audit, COA did not have timelines or time frames for the QOC concern process outlined in policy. During the interview, staff members indicated that the MCE's goal is for 90 percent of QOC concerns to be closed in 90 days. 

To address these opportunities for improvement (both PH and BH), HSAG recommends:

- COA continue ongoing staff training on the Colorado-specific QOCG process.
- COA review and update applicable policies and process documents to:
  - Incorporate contract requirements.
  - Include a process for reporting to the Department.
  - Include information about the goal for completing QOC investigations.
- COA's QM department continue to work in tandem with the grievance department to send out acknowledgment and resolution letters to members/member advocates. Additionally, COA could implement a process for QOCC tracking to capture dates or other evidence that these letters were sent by the grievance team.
- COA develop a more regular reporting process to notify the Department of QOCCs received, according to contractual requirements. Currently, COA is reporting this information to the Department annually.
- DHMP strengthen mechanisms to train staff members and direct the member to COA's call center or website when appropriate.
- DHMP develop proactive monitoring processes for its delegated activities (i.e., regular reporting and trending).
- In response to low numbers of reported QOC complaints, DHMP increase and update training efforts/awareness for internal staff members.
- DHMP review and update applicable policies to clearly articulate the process for delegating/referring BH QOC complaints to COA.

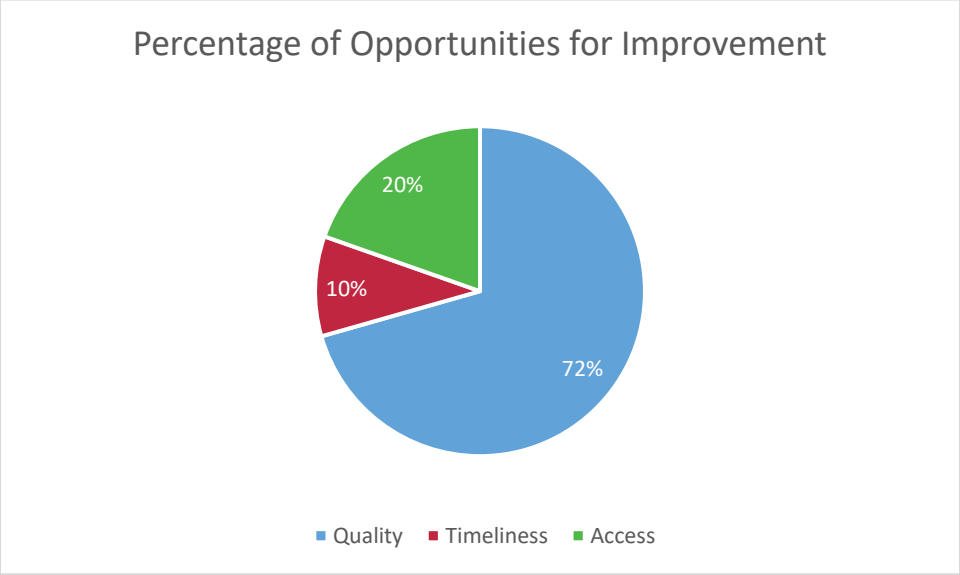
Rocky Mountain Health Plans Medicaid Prime

Figure 3-17—Percentage of Strengths by Care Domain for RMHP Prime*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 3-18—Percentage of Opportunities for Improvement by Care Domain for RMHP Prime*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are RMHP Prime's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of RMHP Prime's Performance Improvement Project

Validation Activities and Interventions

In FY 2021–2022, RMHP Prime continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, RMHP Prime established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-98 and Table 3-99 summarize RMHP Prime's PIP activities that were completed and validated in FY 2020–2021. Table 3-98 provides the SMART Aim statements that RMHP Prime defined for the two PIP outcome measures in Module 1.

Table 3-98—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP for RMHP Prime

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 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 0.55% to 20.0%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement*	By June 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 RMHP Prime Members who screen positive for depression that are successfully connected to appropriate BH services within 30 days from 37.50% to 46.89%.

**The SMART Aim statement was revised in June 2021. HSAG approved revisions to the SMART Aim statement in June 2021 in response to RMHP Prime's correction of data queries used to produce the baseline percentage.*

Table 3-99 summarizes the preliminary key drivers and potential interventions RMHP Prime identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-99—Preliminary Key Drivers and Potential Interventions 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 BH 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 BH follow-up. • Expand utilization of telehealth services to provide follow-up behavioral services.

FY 2021–2022 PIP Activities

In FY 2021–2022, RMHP Prime continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, RMHP Prime developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, RMHP Prime submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as RMHP Prime carried out PDSA cycles to evaluate intervention effectiveness. Table 3-100 presents the FY 2021–2022 Module 3 validation findings for RMHP Prime's four interventions.

Table 3-100—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Develop, implement, and train MAs and providers on a new workflow to score, document, and correctly code depression screens with a negative result (G8510) and positive result (G8431)	• MA does not calculate score and submit to superbill • PHQ-2/PHQ-9 is scored and billed incorrectly	• Provider, care team, and billing/coding education regarding proper coding of positive and negative depression screen for Prime	• Percentage of depression screenings completed for Prime members by MFHC for which a negative depression screen coded G8510 was submitted for billing • Percentage of depression screenings completed for Prime members by MFHC for which a positive depression screen coded G8431 was submitted for billing
Develop and deploy a registry for patients who score positive on PHQ-9 to guide BHAs to connect to patients for BH follow-up when appropriate	• Patient has a positive PHQ-9, but PHQ-9 report does not accurately capture all patients • Community BH providers not accepting new patients • Patient does not prioritize BH visit as part of medical services	• Implement PHQ strategy for follow-up interaction with patients who screen positive for depression	• Percentage of Prime members with a positive depression screen coded G8431, referred to BH services using the PHQ-9 report, who scheduled a follow-up visit with a BHA within 30 days of positive screen
Integrate G-codes into workflow to ensure proper measurement capture of G8431 & G8450. Review and revise SMFM workflow for using G-codes	• Depression screening occurred but was not billed for • Providers could not code	• Use G-codes when screening for depression	• Percentage of Prime members seen by the partner provider who were screened for depression and had the appropriate G-code entered in the data system • Percentage of positive depression screen (G8431) claims for Prime members submitted by the partner provider that were paid • Percentage of negative depression screen (G8510) claims for Prime members

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
			submitted by the partner provider that were paid
Create a standardized depression screening billing and CPT coding workflow for the partner provider	• Code is not entered • Code is entered incorrectly	• Bill for follow-up	• Percentage of Prime members seen by the partner provider who received a PHQ score of 8 or higher and for whom at least one BH intervention code was billed

In Module 3, RMHP Prime selected four interventions to test for the PIP. The interventions addressed process gaps or failures related to appointment access and attendance, and coding and billing practices for depression screening and follow-up services. For each intervention, RMHP Prime defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

Validation Status

The PIP did not progress to receiving a validation status in FY 2021–2022. Following the rapid-cycle PIP process, which spans multiple fiscal years, RMHP Prime continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- Selected four interventions to address key drivers and failure modes related to depression screening and follow-up care processes and to facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of four interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. RMHP Prime addressed all Module 3 PIP validation criteria.

To support successful progression of RMHP Prime's PIP in the next fiscal year, HSAG recommends:

- RMHP Prime collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- RMHP Prime ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, RMHP Prime should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, RMHP Prime should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

HEDIS Measure Rates and Validation

RMHP Prime: Information Systems Standards Review

According to the HEDIS MY 2021 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 performance measure reporting. Please note HSAG could not confirm that the LO for RMHP Prime conducted source code review for the non-HEDIS measures.

RMHP Prime: Performance Measure Results

Table 3-101 shows the performance measure results for RMHP Prime for MY 2019 through MY 2021, along with the percentile ranking for each MY 2021 rate, if available. Rates for MY 2021 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2021 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Table 3-101—Performance Measure Results for RMHP Prime

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
Ages 50 to 64 Years[SA]	—	—	40.89%	BSA
Ages 65 to 74 Years[SA]	—	—	39.03%	ASA
Cervical Cancer Screening				
Cervical Cancer Screening[H]	39.39%	40.27%	42.34%	<10th
Child and Adolescent Well-Care Visits				
Total[H]	—	19.40%	23.86%^	<10th
Childhood Immunization Status				
Combination 3[H]	—	—	—	NA
Combination 7[H]	—	—	—	NA
Combination 10[H]	—	—	—	NA
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	49.55%	45.08%	41.67%	10th–24th
Ages 21 to 24 Years[H]	47.28%	45.02%	45.10%	<10th
Developmental Screening in the First Three Years of Life				
Total[CS]	—	—	—	NA
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)[H]	—	—	64.71%	<10th
Combination 2 (Meningococcal, Tdap, HPV)[H]	—	—	8.82%	<10th
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[SA]	—	—	7.69%	ASA
Ages 18 to 64 Years[SA]	—	—	7.28%	ASA
Ages 65 Years and Older[SA]	—	—	2.37%	ASA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[H]	5.86%	5.83%	12.32%^	<10th
Counseling for Nutrition—Total[H]	20.08%	20.42%	21.83%	<10th
Counseling for Physical Activity—Total[H]	1.26%	0.00%	2.82%	<10th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	—	—	—	NA
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits[H]	—	—	—	NA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age				
Total[SA]	—	—	—	NA
Contraceptive Care—All Women				
LARC—Ages 15 to 20 Years[CS]	—	—	6.51%	ACSM
LARC—Ages 21 to 44 Years[CS]	—	—	4.87%	BCSM
MMEC—Ages 15 to 20 Years[CS]	—	—	33.58%	ACSM
MMEC—Ages 21 to 44 Years[CS]	—	—	20.17%	BCSM
Contraceptive Care—Postpartum Women				
LARC—3 Days—Ages 15 to 20 Years[CS]	—	—	0.00%	BCSM
LARC—3 Days—Ages 21 to 44 Years[CS]	—	—	0.00%	BCSM
LARC—60 Days—Ages 15 to 20 Years[CS]	—	—	19.57%	ACSM
LARC—60 Days—Ages 21 to 44 Years[CS]	—	—	16.56%	ACSM
MMEC—3 Days—Ages 15 to 20 Years[CS]	—	—	0.00%	BCSM
MMEC—3 Days—Ages 21 to 44 Years[CS]	—	—	5.77%	BCSM
MMEC—60 Days—Ages 15 to 20 Years[CS]	—	—	34.78%	BCSM
MMEC—60 Days—Ages 21 to 44 Years[CS]	—	—	40.74%	BCSM
Elective Delivery				
*Ages 18 to 64 Years**[SA]	—	—	48.09%	ASA
Prenatal and Postpartum Care				
Postpartum Care[H]	35.92%	32.89%	36.95%	<10th
Timeliness of Prenatal Care[H]	42.00%	56.65%	56.53%	<10th
Care of Acute and Chronic Conditions				
Asthma in Younger Adults Admission Rate*				
Ages 18 to 39 Years[CS]	—	—	6.65	BCSM
Asthma Medication Ratio				
Total (Ages 5 to 18 Years)[CS]	—	—	—	NA
Total (Ages 19 to 64 Years)[CS]	—	—	57.22%	ACSM
COPD or Asthma in Older Adults Admission Rate*				
Ages 40 to 64 Years[SA]	—	—	258.84	ASA
Ages 65 Years and Older[SA]	—	—	1210.72	ASA
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)*				
Ages 18 to 64 Years[SA]	—	—	69.74%	ASA
Ages 65 to 75 Years[SA]	—	—	66.67%	ASA
Controlling High Blood Pressure				
Ages 18 to 64 Years[SA]	—	—	25.22%	BSA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Ages 65 to 85 Years[SA]	—	—	25.37%	BSA
Diabetes Short-Term Complications Admission Rate*				
Ages 18 to 64 Years[SA]	—	—	27.29	ASA
Ages 65 Years and Older[SA]	—	—	18.41	ASA
Heart Failure Admission Rate*				
Ages 18 to 64 Years[SA]	—	—	76.05	ASA
Ages 65 Years and Older[SA]	—	—	1033.38	ASA
HIV Viral Load Suppression				
Ages 18 to 64 Years[SA]	—	—	0.00%	ASA
Ages 65 Years and Older[SA]	—	—	—	NA
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	—	—	59.11%	25th–49th
Antidepressant Medication Management				
Effective Acute Phase Treatment—Ages 18 to 64 Years[SA]	—	—	57.44%	BSA
Effective Acute Phase Treatment—Ages 65 Years and Older[SA]	—	—	—	NA
Effective Continuation Phase Treatment—Ages 18 to 64 Years[SA]	—	—	39.67%	BSA
Effective Continuation Phase Treatment—Ages 65 Years and Older[SA]	—	—	—	NA
Concurrent Use of Opioids and Benzodiazepines*				
Ages 18 to 64 Years[SA]	—	—	14.93%	ASA
Ages 65 Years and Older[SA]	—	—	19.29%	ASA
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%)*				
Ages 18 to 64 Years[SA]	—	—	58.37%	ASA
Ages 65 to 75 Years[SA]	—	—	—	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[H]	—	—	75.52%	25th–49th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Ages 18 to 64 Years[SA]	—	—	—	NA
7-Day Follow-Up—Ages 65 Years and Older[SA]	—	—	—	NA
30-Day Follow-Up—Ages 18 to 64 Years[SA]	—	—	—	NA
30-Day Follow-Up—Ages 65 Years and Older[SA]	—	—	—	NA
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	38.74%	50th–74th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	54.05%	50th–74th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	—	NA
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	38.84%	50th–74th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	—	NA
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	56.51%	50th–74th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	—	—	NA
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	—	—	—	NA
Continuation and Maintenance Phase[H]	—	—	—	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Initiation of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Initiation of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Initiation of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Initiation of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Initiation of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Initiation of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Initiation of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Engagement of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Engagement of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Engagement of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Engagement of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Engagement of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Engagement of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Engagement of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years[SA]	—	—	—	NA
Engagement of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older[SA]	—	—	—	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[H]	43.33%	62.50%	47.37%	25th–49th
Cholesterol Testing—Total[H]	26.67%	34.38%	36.84%	50th–74th
Blood Glucose and Cholesterol Testing—Total[H]	26.67%	34.38%	34.21%	50th–74th
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total[H]	—	—	—	NA
Use of Opioids at High Dosage in Persons Without Cancer*				
Ages 18 to 64 Years[SA]	—	—	4.11%	ASA
Ages 65 Years and Older[SA]	—	—	2.48%	ASA
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	—	—	52.74%	ASA
Rate 2: Buprenorphine[SA]	—	—	31.66%	ASA
Rate 3: Oral Naltrexone[SA]	—	—	4.13%	ASA
Rate 4: Long-Acting Injectable Naltrexone[SA]	—	—	0.72%	ASA
Rate 5: Methadone[SA]	—	—	20.54%	ASA
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	34.94	NA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Plan All-Cause Readmissions				
Observed Readmissions—Total[H]	9.87%	9.34%	7.92%	<10th
Expected Readmissions—Total[H]	—	—	9.83%	50th–74th
*O/E Ratio—Total**[H]	1.02	0.93	0.81	≥90th

**For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
BSA indicates the reported rate was below the statewide average.
ASA indicates the reported rate was above the statewide average.
BCSM indicates the reported rate was below the Core Set Median.
ACSM indicates the reported rate was above the Core Set Median.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

RMHP Prime: Strengths

The following HEDIS MY 2021 measure rate was determined to be a high-performing rate for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2020, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2020):

- *O/E Ratio—Total*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates for RMHP Prime (i.e., above the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years* and *MMEC—Ages 15 to 20 Years*
- *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15 to 20 Years* and *60 Days—Ages 21 to 44 Years*
- *Asthma Medication Ratio—Total (Ages 19 to 64 Years)*
- *O/E Ratio — Total*

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

The following MY 2021 HEDIS 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 2020):

- *Cervical Cancer Screening* 
- *Child and Adolescent Well-Care Visits—Total* 
- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Ages 21 to 24 Years* 
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* 
- *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* and *Timeliness of Prenatal Care* 

The following non-HEDIS MY 2021 Core Set measure rates were determined to be low-performing rates for RMHP Prime (i.e., fell below the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 21 to 44 Years* and *MMEC—Ages 21 to 44 Years* 
- *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*, *MMEC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*, and *MMEC—60 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years* 
- *Asthma in Younger Adults Admission Rate—Ages 18 to 39 Years* 

To address these low measure rates, HSAG recommends RMHP Prime:

- As it relates to immunizations, remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccination.[3-3]

[3-3] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 21, 2022.

- As it relates to well-care visits, promote well-care visits with providers as an opportunity for providers to influence health and development, and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-4]
- As it relates to source code review, ensure a complete review of the calculation of the non-HEDIS measures and the HEDIS measures where the Core Set specifications differ from NCQA specifications (i.e., additional age stratifications) is performed by the LO.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Prime Overall Evaluation

Table 3-102 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 2021–2022.

Table 3-102—Summary of RMHP Prime Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
Standard V—Member Information Requirements	18	18	16	2	0	0	89%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**39**	**2**	**0**	**0**	**95%**

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

Record reviews were not conducted for the standards reviewed in FY 2021–2022.

[3-4] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 21, 2022.

RMHP Prime: Trended Performance for Compliance With Regulations

Table 3-103—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, 2021–2022)	**100%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**86%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2018–2019, 2021–2022)	**83%**	**89%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2019–2020)	89%	86%
Standard VII—Provider 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, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2020–2021)	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019, 2021–2022)	**100%**	**100%**

**Bold text indicates standards that were reviewed in FY 2021–2022.*

In FY 2021–2022, each of the standards reviewed for RMHP Prime demonstrated consistent high-achieving scores or improvement from the previous review year, indicating a strong understanding of most federal and State regulations.

RMHP Prime: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- RMHP Prime's care management department included diversified staff members including RNs, BH specialists, social workers, and care coordinators. Additionally, the care management department included integrated care coordination teams that worked within communities across the region.

- RMHP Prime supported member feedback and complaints through the customer service phone line and emails. RMHP Prime staff members discussed that the Member Experience Advisory Council reviews grievance reports monthly, and RMHP Prime leadership receives and reviews the grievance reports daily and are able to promptly address issues relating to member rights.
- RMHP Prime demonstrated robust processes to ensure that specific documents available electronically on the RMHP Prime website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the W3C Web Content Accessibility Guidelines. HSAG conducted an accessibility test on a selection of member-specific webpages using the WAVE Web Accessibility Evaluation Tool and found minimal to no errors.
- RMHP Prime made efforts to provide members with information about EPSDT services within 60 days of enrollment, which included the *Health First Colorado Member Handbook*, the *Getting Started Guide*, welcome calls, and screening assessments. Throughout the year, RMHP Prime distributed additional reminders regarding EPSDT services such as educational fliers, annual EPSDT member notifications, care gap outreach in the form of letters and telephone calls, peripheral communications on social media platforms, and other age-specific materials.

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

HSAG found the following opportunities for improvement:

- RMHP Prime did not send any follow-up information to members after the outreach call detailing the care coordination information provided over the phone to the member.
- Critical informational materials did not include all required components of a tagline, some member informational and supplemental materials tested above the required sixth-grade reading level, and RMHP Prime did not consistently inform members that information provided electronically to members is available in paper form "within five business days" on its websites. Additionally, policies did not have current federal language regarding the timeline to notify members of provider termination, which was updated in December 2020 to include "or 30 days prior to the effective date of termination."
- RMHP Prime's documents did not clearly explain that EPSDT services are available to members ages 0 to 20, at no cost (with certain exceptions), and did not contain full details regarding the definition of "medical necessity." RMHP Prime staff members were limited to EPSDT desktop references and current resources to make referrals with State health agencies and programs. Furthermore, RMHP Prime submitted limited documentation to verify how EPSDT considerations are processed within the UM department.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Consider sending a follow-up letter to the member detailing the information provided during the care coordination outreach call.
- Enhance monitoring mechanisms to ensure all required member informational materials are at the sixth-grade reading level, to the extent possible; revise critical informational materials to include all required components of a tagline; align information consistently across websites to include that information provided electronically is available in paper form and provided to the member within five business days; and update the applicable policy to include "or 30 days prior to the effective date of the termination" when notifying the member of provider termination.
- Clarify EPSDT documents to include that EPSDT services are available, at no cost, for all members ages 20 and under. Additionally, clarify within the provider manual that, while some services are not within the RMHP Prime benefit, the EPSDT services are covered under the Health First Colorado benefit and medically necessary services are not at the convenience of the caretaker/parent/guardian, provider, or member. Furthermore, expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process.

Validation of Network Adequacy

RMHP Prime: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- RMHP Prime met all minimum time and distance requirements for Adult, Family and Pediatric Primary Care Practitioners (MD, DO, NP, CNS) and Adult, Family and Pediatric Primary Care Practitioners (PA) across all contracted counties.

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

HSAG found the following opportunities for improvement:

- RMHP Prime did not meet the minimum time and distance requirements for Gynecology OB/GYN (MD, DO, NP, CNS), Gynecology OB/GYN (PA), Acute Care Hospitals, and Pharmacies for multiple counties.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends RMHP Prime:

- Seek opportunities to expand the care network to ensure adequate network providers and access to care, as well as maintain online network provider directories for accurate representation of the current network.

Encounter Data Validation—RMHP Prime 412 Audit Over-Read

FY 2021–2022 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 3-104 presents RMHP Prime's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-104—FY 2021–2022 Self-Reported EDV Results by Data Element and Service Category for RMHP Prime

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	91.3%	75.7%	59.2%	89.3%
Through Date	93.2%	NA	NA	NA
Primary Diagnosis Code	90.3%	74.8%	55.3%	89.3%
Primary Surgical Procedure Code	94.2%	NA	NA	NA
Discharge Status	91.3%	NA	NA	NA
Procedure Code	NA	75.7%	55.3%	85.4%
Procedure Code Modifier	NA	74.8%	57.3%	87.4%
Units	NA	73.8%	56.3%	88.3%

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

Table 3-105 presents RMHP Prime's FY 2021–2022 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 78 of the 80 sampled encounters, resulting in a 97.5 percent agreement rate. The overall agreement rate was higher than the overall agreement rate from the FY 2020–2021 EDV study.

Table 3-105—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for RMHP Prime

	Case-Level Accuracy		Element-Level Accuracy	
Service Category	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	95.0%	120	95.0%
Outpatient	20	100.0%	100	100.0%
Professional	20	100.0%	100	100.0%
FQHC	20	95.0%	100	99.0%
Total	**80**	**97.5%**	**420**	**98.3%**

RMHP Prime: Strengths

Based on MCO 412 EDV activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- HSAG agreed with 98.3 percent of RMHP Prime's internal validation results for the total number of individual data elements reviewed. This number is higher than the 94.8 percent agreement rate reported for RMHP Prime in FY 2020–2021.
- Results from HSAG's over-read suggest a high level of confidence that RMHP Prime's independent validation findings accurately reflect the encounter data quality summarized in RMHP Prime's service coding accuracy results.
- Overall, the FY 2021–2022 results indicate complete case-level agreement with RMHP Prime's internal validation for 97.5 percent of cases.
- HSAG's review of the study documentation provided by the Department and RMHP Prime suggests that all parties followed the guidelines while conducting the EDV.

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

HSAG found the following opportunities for improvement:

- RMHP Prime's service coding accuracy results show that the accuracy rates for the professional data elements did not exceed 60.0 percent and the accuracy rates for the outpatient elements did not exceed 76.0 percent.
- In total, 10 of the individual data elements (there are a total of 20 elements across the encounter types) reported rates of less than 80.0 percent.

To address the opportunities for improvement, HSAG recommends RMHP Prime:

- Consider internal data monitoring and provider training to improve medical record documentation.

CAHPS Survey

Table 3-106 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2019–2020 through FY 2021–2022.

Table 3-106—Adult Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	68.3%	55.1%	58.5%
Rating of All Health Care	58.6%	53.9%	49.3% ↓
Rating of Personal Doctor	75.1%	67.9%	61.2% ↓
Rating of Specialist Seen Most Often	66.7%+	69.7%+	71.1%+
Getting Needed Care	84.5%	83.5%	83.6%
Getting Care Quickly	83.1%	80.2%+	80.2%
How Well Doctors Communicate	93.4%	92.1%	87.4% ↓
Customer Service	94.7%+	89.7%+	88.7%+

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

RMHP Prime: Adult Medicaid Strengths

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were higher, although not statistically significantly, than the 2021 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were higher, although not statistically significantly, than the FY 2020–2021 scores:

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

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

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

For the adult population, the following measures' FY 2021–2022 scores for RMHP Prime were lower, although not statistically significantly, than the FY 2020–2021 scores:

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

To address these low CAHPS scores, HSAG recommends RMHP Prime:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including communications programs for providers or care reminders to encourage timely requests for services by the members.

Table 3-107 shows the child Medicaid CAHPS results achieved by RMHP Prime for FY 2019–2020 through FY 2021–2022.

Table 3-107—Child Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	NA	69.9%	68.7%
Rating of All Health Care	NA	74.7%	63.2% ↓ ▼
Rating of Personal Doctor	NA	75.0%	69.4% ↓

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Specialist Seen Most Often	NA	73.0%+	79.6%+
Getting Needed Care	NA	86.3%	85.4%
Getting Care Quickly	NA	91.1%	87.5%
How Well Doctors Communicate	NA	97.4%	96.8% ↑
Customer Service	NA	89.3%+	89.1%+

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.
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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

RMHP Prime: Child Medicaid Strengths

For the child population, the following measure's FY 2021–2022 score for RMHP Prime was statistically significantly higher than the 2021 NCQA national average:

- *How Well Doctors Communicate*

For the child population, the following measure's FY 2021–2022 score for RMHP Prime was higher, although not statistically significantly, than the FY 2020–2021 score:

- *Rating of Specialist Seen Most Often*

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

The following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

The following measure's FY 2021–2022 score for RMHP Prime was statistically significantly lower than the FY 2020–2021 score:

- *Rating of All Health Care*

To address these low CAHPS scores, HSAG recommends RMHP Prime:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance including enhancing provider informational materials and exploring providers' ability to communicate effectively with members.

Quality Improvement Plan

Table 3-108 presents RMHP Prime's encounter data type accuracy from baseline through the three months post intervention for all claim types.

Table 3-108—Summary of RMHP Prime QUIP Outcomes

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
Inpatient	Date of Service	87%	100%	100%	93%
	Through Date	86%	100%	100%	93%
	Diagnosis Code	76%	100%	100%	87%
	Surgical Procedure Code	57%	100%	100%	93%
	Discharge Status	78%	93%	100%	93%
Outpatient	Date of Service	89%	100%	100%	100%
	Diagnosis Code	85%	100%	100%	100%
	Procedure Code	88%	87%	100%	100%
	Procedure Code Modifier	88%	100%	100%	100%
	Units	87%	87%	100%	100%
Professional	Date of Service	81%	100%	100%	100%
	Diagnosis Code	72%	93%	93%	100%
	Procedure Code	77%	100%	100%	100%
	Procedure Code Modifier	73%	100%	100%	100%
	Units	77%	100%	100%	100%

Claim Type	Encounter Data Type	Baseline	First Month	Second Month	Third Month*
FQHC	Date of Service	74%	93%	100%	100%
	Procedure Code Modifier	67%	100%	93%	93%

**Red shading indicates accuracy less than 90 percent; green shading indicates accuracy of 90 percent and higher.*

RMHP Prime: Strengths

Based on QUIP activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- RMHP Prime experienced improvements in 11 of the encounter data types to 100 percent accuracy, and five of the encounter data types to 93 percent accuracy.
- RMHP Prime reported using the education module as a resource and integrating it into new hire onboarding procedures or continuing education.

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

HSAG found the following opportunities for improvement:

- RMHP Prime reported missing, incorrect, and insufficient documentation in medical records. Common errors included the lack of CPT codes, diagnosis, date of service and admit date, or signatures from rendering providers.
- RMHP Prime identified several root causes, such as the lack of education on evaluation and management (E&M) coding regarding entering the appropriate diagnosis, treatment, services, codes, and documentation; and the lack of a formal process for submission of medical records or record submissions being outsourced to another organization, etc. that resulted in failure modes for the claim types.
- Inpatient *diagnosis code* encounter data type showed improvement in month one and month two from the baseline of 76 percent to 100 percent. However, in month three, there was a decrease to 87 percent accuracy, below the 90 percent threshold.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Continue to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and

professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audit

Table 3-109 displays the MHP Audit compliance scores for RMHP Prime for FY 2021–2022 compared to the FY 2020–2021 compliance scores.

Table 3-109—FY 2021–2022 MHP Audit Score for RMHP Prime

MCO	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
MH/SUD and M/S Services				
RMHP Prime	100%	Inpatient	87%	89%∨
		Outpatient	91%	

∨ *Indicates that the score declined as compared to the previous review year.*

RMHP Prime: Strengths

Based on MHP Audit activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- RMHP Prime used nationally recognized UR criteria, including MCG criteria, for all MH determinations and ASAM level of care criteria for all SUD determinations.
- RMHP Prime followed policies and procedures regarding IRR testing and required UM staff members to participate in IRR testing annually, including requiring an 80 percent passing score.
- Most files demonstrated that RMHP Prime followed its prior authorization list and UM policies and procedures with regard to which services are subject to prior authorization and requirements for processing requests for services.
- All NABDs were written at a reading level that was easy to understand and were sent within the required time frames.
- RMHP Prime offered requesting provider peer-to-peer reviews prior to finalizing a denial determination in nearly all cases.
- During the MHP interview, RMHP Prime reported several best practices related to implementation of the new SUD inpatient and residential benefit package starting in 2021, including monthly training opportunities for providers, provider communications to assist providers in understanding the new SUD benefits, utilizing the state-developed uniform request form for SUD services, and reporting the SUD care coordinator is a member of the UM team to ensure that members receive the appropriate level of care when a particular level of care is denied.

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

HSAG found the following opportunities for improvement:

- Some files were administratively denied due to the provider not yet enrolled with Medicaid but should have been approved for continuity of care reasons.
- RMHP Prime did not consistently offer or have documentation to support that it offered peer-to-peer review to the requesting provider for all cases involving a medical necessity review.
- RMHP Prime often only sent the NABD using the provider template to the provider, with a copy to the member. Additionally, the NABD provider template that was often sent to the member did not include all required content. During the MHP interview, RMHP Prime staff members reported that during CY 2021, it was standard practice to only send a provider letter (with a copy to the member) for denials determined via a concurrent review.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Ensure UM staff members are aware of 42 CFR §438, which allows contracting for period of 120 calendar days while a provider finalizes Medicaid enrollment.
- Evaluate documentation protocols to ensure accuracy of documenting whether peer-to-peer reviews were offered.
- Enhance monitoring mechanisms to ensure the correct NABD template is sent to the member and includes all required content.

Quality of Care Concern Audit

RMHP Prime used CMS' definition of a QOCG. RMHP Prime submitted a *Retrospective Quality Case Review Process Policy and Procedure* for review. However, the MCEs' definition for QOCG is not stated in policy. RMHP Prime had a total of 31 substantiated cases during the review period and used a four-level rating system to define the severity of QOCGs. RMHP's *Retrospective Quality Case Review Process Policy and Procedure* did not define the severity levels. However, RMHP submitted a *Semi-Annual Evaluation Quality of Care* report dated July 1, 2021, through December 31, 2021, that included definitions for each severity level. Professionals with varying qualifications and/or degrees reviewed QOCGs submitted to RMHP.

The following trends were identified within the sample cases reviewed:

- Of the 10 sample cases, seven were non-Hispanic White members.
- Two out of 10 members were disabled.
- Five cases had a severity level of severe, two were moderate, and three were minor.
- Seven out of 10 cases were related to the quality of mental health services, one of which involved a self-harming behavior.
- Three out of 10 cases resulted in a CAP for the provider/facility.

RMHP Prime had a system for identifying and addressing all alleged QOCGs. When a concern was raised, RMHP Prime investigated, analyzed, tracked, trended, and resolved QOCGs according to policy. RMHP Prime adhered to a RMHP Prime policy titled *Retrospective Quality Case Review Process Policy and Procedure*. In addition to the policy, the MCE adhered to a *Quality-of-Care Workflow* developed by RMHP Prime. The workflow provided direction for handling and reviewing QOCGs. Based on review of 10 sample cases and associated documents, HSAG determined that RMHP Prime adhered to its internal policies and procedures.

None of the 10 sample cases reviewed had outcomes reported to a regulatory agency or licensing board. RMHP Prime's policy stated that, if needed, the MCE will report any unethical or member safety issues described within the Mental Health Practice Act to DORA to investigate. The PMD will report all wrongful or unlawful conduct to the Medical Board immediately after review. Additionally, the workflow chart included a step for notifying RMHP Prime's legal department.

RMHP Prime: Strengths

Based on QOCC Audit activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP Prime:

- RMHP Prime's QI program included activities that improve the quality and safety of clinical care and BH services for members. As appropriate, interventions and follow-up for identified QOC issues were developed for the cases reviewed. Policies described a process whereby a QI case

reviewer, medical director, and a QI case review team would investigate, analyze, track, trend, and resolve QOCGs.

- The *Health First Colorado Member Handbook* and information on the MCE's website included information for the member about the process for reporting a grievance. The member materials did not distinguish the difference between a grievance and a QOCG. By means of internal investigation and utilizing the QOCG definition, the grievance team could make a referral to the QI case review team to investigate grievances deemed a potential QOCG.
- The provider manual included information for reporting issues such as adverse events and sentinel events. Within the RMHP Prime provider manual, providers were reminded that all member records requested and referred to the QI case review team would be kept strictly confidential through the entire case referral and review process. During the interview, RMHP Prime staff members stated that RMHP Prime held a seminar for all providers to review the process for reporting sentinel events and to implement the use of a newly developed standardized form for reporting sentinel events to RMHP Prime. During the interview, RMHP Prime staff members stated that providers have communicated to RMHP Prime that a statewide standardized process would ultimately reduce burden on the providers.
- As needed, and according to policy, RMHP Prime reviewed QOCGs with the following:
  - MAC
  - MPRC
  - Credentialing Committee
  - RMHP's legal department
  - CAQI provider workgroup
- RMHP Prime's policy included information for querying its QA database semiannually to identify the number of QOCG cases. Policies and procedures indicated that results are reported to the MAC for review, analysis, and follow-up as needed. The QA database was also queried semiannually for trend analysis. The MCE provided evidence of a MAC report dated July 1, 2021, through December 31, 2021. The *Semi-Annual Evaluation Quality of Care* report provided severity level definitions, the number of QOC cases by level of concern, the number of incoming QOC cases, the type of case, the number of readmission cases, a quality analysis summary, a quantitative analysis, interventions, and opportunities for improvement.
- Starting in quarter one of CY 2022, RMHP Prime began proactively reporting QOCGs to the Department. Historically, RMHP Prime was only reporting to the Department if the Department requested or if a severe or systemic concern was identified. RMHP Prime would also notify the Department if a network provider was terminated. The quarterly report to the Department included all closed cases.

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

HSAG found the following opportunities for improvement:

- While the MCE had a policy and procedure that described a retrospective quality case review process, it lacked detail about letter templates, the acknowledgement and resolution letter process, contract requirements, assigning a severity level, and the CAP process. All QOCGs submitted were reviewed by a medical director. Additionally, during the interview, RMHP Prime staff members reported that there are questions regarding whether RMHP Prime should conduct QOCGs that are related to dental services since RMHP Prime is not the payor for dental services.
- RMHP Prime staff members reported that the QI case review team and grievance team work in tandem if the grievance is reported by a member/member advocate for sending out acknowledgment and resolution letters. The sample cases that resulted in a CAP also had a resolution letter; however, acknowledgement and resolution letters were not present for each sample case reviewed and a process was not outlined in RMHP's *Retrospective Quality Case Review Process Policy and Procedure*. RMHP Prime staff members stated that evidence of a CAP can be provided in the form of an attestation from the facility/provider that the CAP was implemented and completed.
- At the time of this audit, RMHP Prime did not have timelines or time frames for the QOCG process. During the interview, staff members indicated that each QOCG they investigate is unique and it would be difficult to establish timelines or time frames for the process. However, RMHP Prime staff members stated during the interview that they try to follow internal unofficial timelines. Staff members indicated that they would request guidance from the Department for establishing timelines, time frames, and/or goals for handling QOCGs.
- During the interview, RMHP Prime staff members stated that if throughout the review and investigation of a QOCG follow-up with a member needed to occur to ensure the member's immediate healthcare needs were met, the QI case reviewer would request that the care coordination team outreach to the member. None of the sample cases reviewed provided evidence that a care coordinator spoke with a member to ensure their immediate healthcare needs were met. Neither RMHP Prime's policy nor workflow chart described this step in the process.
- RMHP Prime staff members stated that the customer service team received training on what constitutes a QOCG. At the time of the QOCC Audit, RMHP Prime reported working on updating the training materials.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Develop and implement ongoing staff training on the Colorado-specific QOCG process.
- Review and update applicable policies and process documents to:

  - Provide step-by-step procedures for identifying, investigating, addressing, analyzing, tracking, trending, resolving, and reporting QOCGs.
  - Incorporate contract requirements.
  - Add severity levels and definitions.
  - Include a process for reporting to the Department.
  - Incorporate a process for acknowledgment and resolution letters.
  - Establish milestones/timelines/time frames and/or goals for the QOCG process.
- Consider consistently requesting evidence of CAP completion from a facility/provider when a CAP is initiated. For example, if the facility indicated that they revised a policy and provided staff training, RMHP Prime could request a copy of the updated policy, training materials, and list of attendees.
- Continue notifying the Department of QOCGs received. Additionally, RMHP Prime should continue reaching out to the Department to report ad hoc cases with severity rating, systematic concerns, and termination of any network provider.
- Continue to work in tandem with the grievance team to send out acknowledgment and resolution letters to members, along with consistent documentation to capture these letters. RMHP Prime could establish a process for sending acknowledgment and resolution letters to the party reporting the QOCG for all QOCGs, regardless of who reported the QOCG referral.
- Follow up with its contract managers at the Department to resolve questions regarding whether RMHP Prime should conduct QOCGs that are related to dental services since RMHP Prime is not the payor for dental services.

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Statewide Results

Table 4-1 shows the FY 2021–2022 statewide PIP results for the RAEs and the MCOs.

Table 4-1—FY 2021–2022 Statewide PIP Results

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

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2021–2022 validation cycle.*

Statewide Conclusions and Recommendations Related to Validation of PIPs

During FY 2021–2022, the MCEs continued ongoing PIPs focused on *Depression Screening and Follow-Up After a Positive Depression Screen*. The PIPs were initiated in the prior fiscal year when the MCEs had completed the first two modules of the rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination. During this validation cycle, the MCEs submitted Module 3 of the rapid-cycle PIP process for validation. In Module 3—Intervention Testing, the MCE defines the plan for the intervention to be tested. HSAG provided technical assistance and feedback to the MCEs on the intervention testing plan, including the intervention effectiveness measure and data collection process. The MCEs continued testing interventions for the PIP until the end of the fiscal year. In FY 2022–2023, the MCEs will submit the final rapid-cycle PIP module, Module 4—PIP Conclusions for validation and will report the final results, conclusions, and lessons learned for the PIPs.

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. All MCEs addressed all Module 3 PIP validation criteria.

To support successful progression of the PIPs in the next fiscal year, HSAG recommends the following:

- The MCEs should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- The MCEs should ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, the MCEs should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, the MCEs should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the MCEs should document which interventions had the greatest impact.
- Since all MCEs are focusing on the same PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*, the Department should provide an opportunity for the MCEs to share successful improvement strategies and lessons learned with one another once the PIPs are completed. Such an approach may support the spread of successful interventions across the broader Medicaid population, furthering statewide improvement in depression screening and follow-up care outcomes.

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 rates validated in FY 2021–2022 for data from FY 2020–2021 (MY 2021). Cells shaded green indicate the performance met or exceeded the FY 2020–2021 (MY 2020) performance goal (as determined by the Department).

Table 4-2—MY 2021 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 SUD Treatment	47.90%	50.80%	45.09%	48.51%	36.65%	41.61%	54.10%	46.28%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	44.48%	50.07%	56.76%	70.43%	56.03%	64.51%	41.42%	52.99%
Follow-Up Within 7 Days of an ED Visit for SUD	32.46%	29.64%	30.50%	36.49%	35.25%	35.30%	32.75%	33.27%
Follow-Up After a Positive Depression Screen	57.49%	87.09%	43.47%	50.19%	39.21%	47.48%	73.39%	62.88%

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
Behavioral Health Screening or Assessment for Children in the Foster Care System	16.39%	18.60%	15.41%	33.31%	28.57%	17.82%	23.29%	22.04%

Cells shaded green indicate the rate met or exceeded the FY 2020–2021 goal.

Statewide Conclusions and Recommendations

During this measurement period, none of the statewide averages met the goal. Additionally, only two RAEs, NHP and CCHA Region 7, exceeded the goal for any measure, which was *Follow-Up After a Positive Depression Screen*.

HSAG recommends that the RAEs include the results of analyses for the measures listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) and/or initiative(s) is the RAE considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented above, HSAG recommends that 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 MY 2021. 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—MY 2021 MCO and Statewide Results

Performance Measure	DHMP	RMHP Prime	Statewide
Primary Care Access and Preventive Care			
Breast Cancer Screening			
Ages 50 to 64 Years	41.70%	40.89%	41.29%
Ages 65 to 74 Years	30.96%	39.03%	34.32%
Cervical Cancer Screening			
Cervical Cancer Screening	39.36%	42.34%	40.67%
Child and Adolescent Well-Care Visits			
Total	41.93%	23.86%	41.16%
Childhood Immunization Status			
Combination 3	61.92%	—	61.94%
Combination 7	53.08%	—	53.10%
Combination 10	40.22%	—	40.25%
Chlamydia Screening in Women			
Ages 16 to 20 Years	76.77%	41.67%	75.11%
Ages 21 to 24 Years	68.54%	45.10%	57.93%

Performance Measure	DHMP	RMHP Prime	Statewide
Developmental Screening in the First Three Years of Life			
Total	—	—	—
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	64.92%	64.71%	64.92%
Combination 2 (Meningococcal, Tdap, HPV)	35.93%	8.82%	35.48%
Screening for Depression and Follow-Up Plan			
Ages 12 to 17 Years	—	7.69%	7.69%
Ages 18 to 64 Years	—	7.28%	7.28%
Ages 65 Years and Older	—	2.37%	2.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	70.33%	12.32%	69.35%
Counseling for Nutrition—Total	74.36%	21.83%	73.46%
Counseling for Physical Activity—Total	73.75%	2.82%	72.54%
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	54.34%	—	54.34%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	54.42%	—	54.39%
Maternal and Perinatal Health			
Audiological Diagnosis No Later Than 3 Months of Age			
Total	—	—	—
Contraceptive Care—All Women			
LARC—Ages 15 to 20 Years	—	6.51%	6.51%
LARC—Ages 21 to 44 Years	—	4.87%	4.87%
MMEC—Ages 15 to 20 Years	—	33.58%	33.58%
MMEC—Ages 21 to 44 Years	—	20.17%	20.17%
Contraceptive Care—Postpartum Women			
LARC—3 Days—Ages 15 to 20 Years	—	0.00%	0.00%
LARC—3 Days—Ages 21 to 44 Years	—	0.00%	0.00%
LARC—60 Days—Ages 15 to 20 Years	—	19.57%	19.57%
LARC—60 Days—Ages 21 to 44 Years	—	16.56%	16.56%
MMEC—3 Days—Ages 15 to 20 Years	—	0.00%	0.00%
MMEC—3 Days—Ages 21 to 44 Years	—	5.77%	5.77%
MMEC—60 Days—Ages 15 to 20 Years	—	34.78%	34.78%
MMEC—60 Days—Ages 21 to 44 Years	—	40.74%	40.74%
Elective Delivery*			
Ages 18 to 64 Years	—	48.09%	48.09%

Performance Measure	DHMP	RMHP Prime	Statewide
Prenatal and Postpartum Care			
Postpartum Care	70.66%	36.95%	54.89%
Timeliness of Prenatal Care	79.51%	56.53%	68.76%
Care of Acute and Chronic Conditions			
Asthma in Younger Adults Admission Rate*			
Ages 18 to 39 Years	—	6.65	6.65
Asthma Medication Ratio			
Total (Ages 5 to 18 Years)	59.89%	—	59.68%
Total (Ages 19 to 64 Years)	47.38%	57.22%	52.00%
COPD or Asthma in Older Adults Admission Rate*			
Ages 40 to 64 Years	—	258.84	258.84
Ages 65 Years and Older	—	1210.72	1210.72
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)*			
Ages 18 to 64 Years	—	69.74%	69.74%
Ages 65 to 75 Years	—	66.67%	66.67%
Controlling High Blood Pressure			
Ages 18 to 64 Years	48.54%	25.22%	36.77%
Ages 65 to 85 Years	55.92%	25.37%	42.45%
Diabetes Short-Term Complications Admission Rate*			
Ages 18 to 64 Years	—	27.29	27.29
Ages 65 Years and Older	—	18.41	18.41
Heart Failure Admission Rate*			
Ages 18 to 64 Years	—	76.05	76.05
Ages 65 Years and Older	—	1033.38	1033.38
HIV Viral Load Suppression			
Ages 18 to 64 Years	—	0.00%	0.00%
Ages 65 Years and Older	—	—	—
Behavioral Health Care			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	47.54%	59.11%	53.83%
Antidepressant Medication Management			
Effective Acute Phase Treatment—Ages 18 to 64 Years	64.50%	57.44%	60.87%
Effective Acute Phase Treatment—Ages 65 Years and Older	78.00%	—	74.36%
Effective Continuation Phase Treatment—Ages 18 to 64 Years	42.55%	39.67%	41.07%
Effective Continuation Phase Treatment—Ages 65 Years and Older	72.00%	—	64.10%

Performance Measure	DHMP	RMHP Prime	Statewide
Concurrent Use of Opioids and Benzodiazepines*			
Ages 18 to 64 Years	—	14.93%	14.93%
Ages 65 Years and Older	—	19.29%	19.29%
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%)*			
Ages 18 to 64 Years	—	58.37%	58.37%
Ages 65 to 75 Years	—	—	—
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.68%	75.52%	79.50%
Follow-Up After ED Visit for AOD Abuse or Dependence			
7-Day Follow-Up—Ages 18 to 64 Years	15.29%	—	15.29%
7-Day Follow-Up—Ages 65 Years and Older	2.08%	—	2.08%
30-Day Follow-Up—Ages 18 to 64 Years	21.09%	—	21.09%
30-Day Follow-Up—Ages 65 Years and Older	6.25%	—	6.25%
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Ages 18 to 64 Years	21.44%	38.74%	26.47%
7-Day Follow-Up—Ages 65 Years and Older	—	—	—
30-Day Follow-Up—Ages 18 to 64 Years	29.02%	54.05%	36.30%
30-Day Follow-Up—Ages 65 Years and Older	—	—	—
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Ages 6 to 17 Years	—	—	—
7-Day Follow-Up—Ages 18 to 64 Years	8.54%	38.84%	33.98%
7-Day Follow-Up—Ages 65 Years and Older	—	—	—
30-Day Follow-Up—Ages 6 to 17 Years	—	—	—
30-Day Follow-Up—Ages 18 to 64 Years	15.85%	56.51%	50.00%
30-Day Follow-Up—Ages 65 Years and Older	—	—	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	30.95%	—	31.87%
Continuation and Maintenance Phase	—	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years	41.07%	—	41.03%
Initiation of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older	61.05%	—	61.05%
Initiation of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years	40.41%	—	40.41%

Performance Measure	DHMP	RMHP Prime	Statewide
Initiation of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older	51.52%	—	51.52%
Initiation of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years	54.55%	—	54.44%
Initiation of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older	—	—	—
Initiation of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years	42.20%	—	42.16%
Initiation of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older	61.38%	—	61.38%
Engagement of AOD—Alcohol Abuse or Dependence—Ages 18 to 64 Years	6.32%	—	6.32%
Engagement of AOD—Alcohol Abuse or Dependence—Ages 65 Years and Older	6.32%	—	6.32%
Engagement of AOD—Other Drug Abuse or Dependence—Ages 18 to 64 Years	3.67%	—	3.67%
Engagement of AOD—Other Drug Abuse or Dependence—Ages 65 Years and Older	3.03%	—	3.03%
Engagement of AOD—Opioid Abuse or Dependence—Ages 18 to 64 Years	14.02%	—	14.02%
Engagement of AOD—Opioid Abuse or Dependence—Ages 65 Years and Older	—	—	—
Engagement of AOD—Total AOD Abuse or Dependence—Ages 18 to 64 Years	6.40%	—	6.40%
Engagement of AOD—Total AOD Abuse or Dependence—Ages 65 Years and Older	6.90%	—	6.90%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	—	47.37%	59.09%
Cholesterol Testing—Total	—	36.84%	45.45%
Blood Glucose and Cholesterol Testing—Total	—	34.21%	43.94%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	—	—	—
Use of Opioids at High Dosage in Persons Without Cancer*			
Ages 18 to 64 Years	—	4.11%	4.11%
Ages 65 Years and Older	—	2.48%	2.48%
Use of Pharmacotherapy for Opioid Use Disorder			
Rate 1: Total	—	52.74%	52.74%
Rate 2: Buprenorphine	—	31.66%	31.66%

Performance Measure	DHMP	RMHP Prime	Statewide
Rate 3: Oral Naltrexone	—	4.13%	4.13%
Rate 4: Long-Acting Injectable Naltrexone	—	0.72%	0.72%
Rate 5: Methadone	—	20.54%	20.54%
Use of Services			
Ambulatory Care: ED Visits			
ED Visits—Total	22.47	34.94	22.66
Plan All-Cause Readmissions			
Expected Readmissions—Total	9.63%	9.83%	9.71%
Observed Readmissions—Total	9.51%	7.92%	8.85%
O/E Ratio—Total	0.99	0.81	0.91

**For this indicator, a lower rate indicates better performance.*
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.

Statewide Conclusions and Recommendations Related to HEDIS Measure Rates and Validation

The following MY 2021 HEDIS 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 2020 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2020):

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates (i.e., ranked above the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years* and *MMEC—Ages 15 to 20 Years*
- *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*

The following MY 2021 HEDIS measure rates were determined to be low-performing rates (i.e., ranked below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2020) for the MCOs:

- *Cervical Cancer Screening*

- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Ages 18 to 64 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be low-performing rates (i.e., ranked below the Core Set Median):

- *Contraceptive Care—All Women—LARC—Ages 21 to 44 Years* and *MMEC—Ages 21 to 44 Years*
- *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*, *MMEC—3 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*, and *MMEC—60 Days—Ages 15 to 20 Years* and *Ages 21 to 44 Years*
- *Asthma in Younger Adults Admission Rate—Ages 18 to 39 Years*
- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)* and *Total (Ages 19 to 64 Years)*

To address these low measure rates, HSAG recommends:

- As it relates to immunizations, reminding parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccination.[4-1]
- As it relates to well-care visits, promoting visits provides an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[4-2]

[4-1] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 21, 2022.

[4-2] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 21, 2022.

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 (2021–2022)	**100%**	**100%**	**100%**	**100%**	**100%**	**90%**	**90%**	**97%**
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Standard V—Member Information Requirements (2021–2022)	**89%**	**86%**	**94%**	**86%**	**94%**	**87%**	**87%**	**89%**
Standard VI—Grievance and Appeal Systems (2019–2020)	86%	77%	80%	83%	83%	71%	74%	79%
Standard VII—Provider 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, Clinical Practice Guidelines, and	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
Health Information Systems (2020–2021)								
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	**100%**	**86%**	**100%**	**86%**	**100%**	**86%**	**86%**	**92%**

Bold text indicates standards that HSAG reviewed during FY 2021–2022.

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 (2021–2022)	**100%**	**100%**	**100%**
Standard IV—Member Rights, Protections and Confidentiality (2021–2022)	**100%**	**100%**	**100%**
Standard V—Member Information Requirements (2021–2022)	**78%**	**89%**	**84%**
Standard VI—Grievance and Appeal Systems (2019–2020)	83%	86%	86%
Standard VII—Provider 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, Clinical Practice Guidelines, and Health Information Systems (2020–2021)	94%	100%	97%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	**100%**	**100%**	**100%**

Bold text indicates standards that HSAG reviewed during FY 2021–2022.

Statewide Conclusions and Recommendations Related to Assessment of Compliance

Based on the four standards reviewed in FY 2021–2022, the Medicaid health plans demonstrated compliance and opportunities for improvement in many areas. Most (five or more) Medicaid health plans statewide—both the RAEs and MCOs:

- Received 100 percent compliance for Standard IV—Member Rights, Protections, and Confidentiality and demonstrated a thorough understanding of federal and State regulations. Each RAE and MCO submitted and described detailed policies, procedures, and provider and member informational materials that outlined member rights and protections.
- Demonstrated a comprehensive understanding of Standard III—Coordination and Continuity of Care and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services as many health plans received 100 percent compliance scores. Most Medicaid health plans had policies and procedures to assess and coordinate services to all members including those with complex, health-risk, and special health care needs. Additionally, the health plans made best efforts using various methods of communication to inform eligible members about EPSDT services.
- Presented frequent issues that resulted in opportunities for improvement related to Standard V—Member Information Requirements. Frequent issues for both the RAEs and MCOs included not including all required components of a tagline, not updating applicable policy and procedure language to address December 2020 federal language revisions to the timeline for sending members notice of provider termination, and not implementing proper mechanisms to monitor timely ad hoc printing requests for member informational materials.

For Medicaid health plans statewide—both the RAEs and MCOs—the most common opportunities for improvement were the following:

- Many health plans did not send any follow-up information after the care coordination outreach call detailing information provided over the phone to the member. HSAG recommends the health plans consider sending a follow-up letter to the member detailing the information provided during the outreach call should the member want to reach out to their care coordinator.
- Member-facing websites that contained critical informational materials did not consistently state that information provided electronically is available in paper form and is provided to the member within five business days. Additionally, many health plans did not provide supporting documentation to demonstrate a mechanism of how the health plan monitors the timeliness of ad hoc printing requests.
- Critical informational materials did not include all required components of a tagline. Applicable policies and procedures did not have the updated timeline to notify members of provider termination aligning with December 2020 federal language revisions to include "of 30 days prior to the effective date of the termination."

- Some health plans relied on the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services. However, the welcome letter and *Health First Colorado Member Handbook* did not contain all required components, specifically, the health plan's website address.
- There was limited documentation verifying how EPSDT considerations were processed within the UM department. Additionally, multiple health plans did not consistently outreach members who had not utilized services in the prior 12-month period and the plans did not utilize various communication methods to ensure that outreach is timely and has a reasonable chance of reaching the member.

Validation of Network Adequacy

Statewide Results

Quarterly during FY 2021–2022, HSAG validated the MCEs' self-reported compliance with minimum network requirements and provided the Department with both MCE-specific initial file review results in the network adequacy data initial validation (NADIV) dashboards and final validation results in quarterly NAV dashboards.

The data-related findings in this report align with HSAG's validation of the MCEs' FY 2021–2022 Quarter 2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2021, through December 31, 2021.

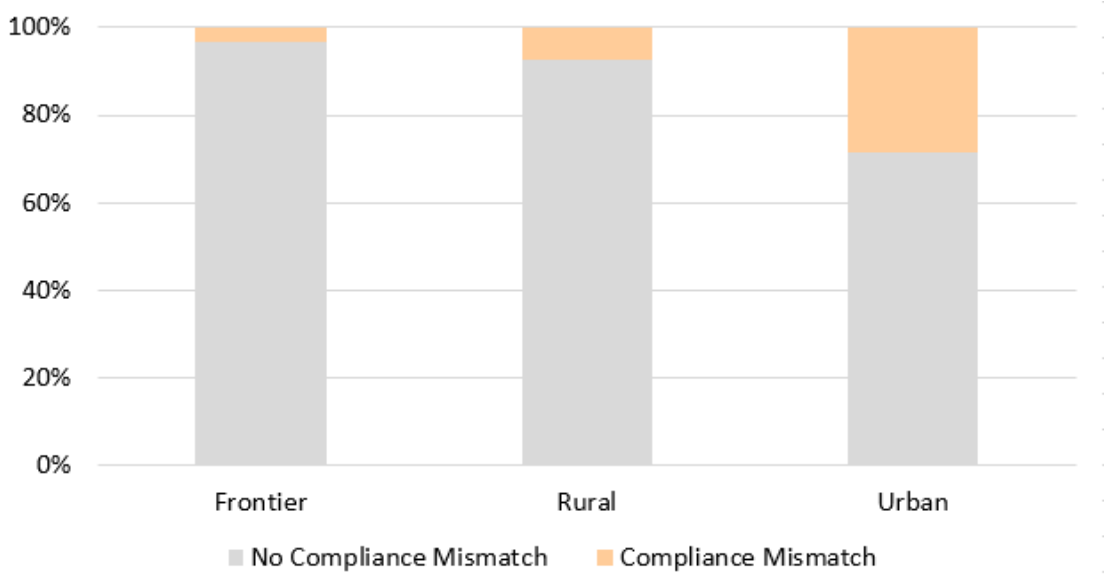
For an MCE to be compliant with the FY 2021–2022 minimum network requirements, the MCE is required to ensure that its practitioner network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level). For example, all members residing 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 MCE's contracted geographic area, the Department does not necessarily require the MCE to meet the minimum network requirements for those members. Additionally, the MCE 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).

Regional Accountable Entities

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 2021–2022 Quarter 2 by Urbanicity

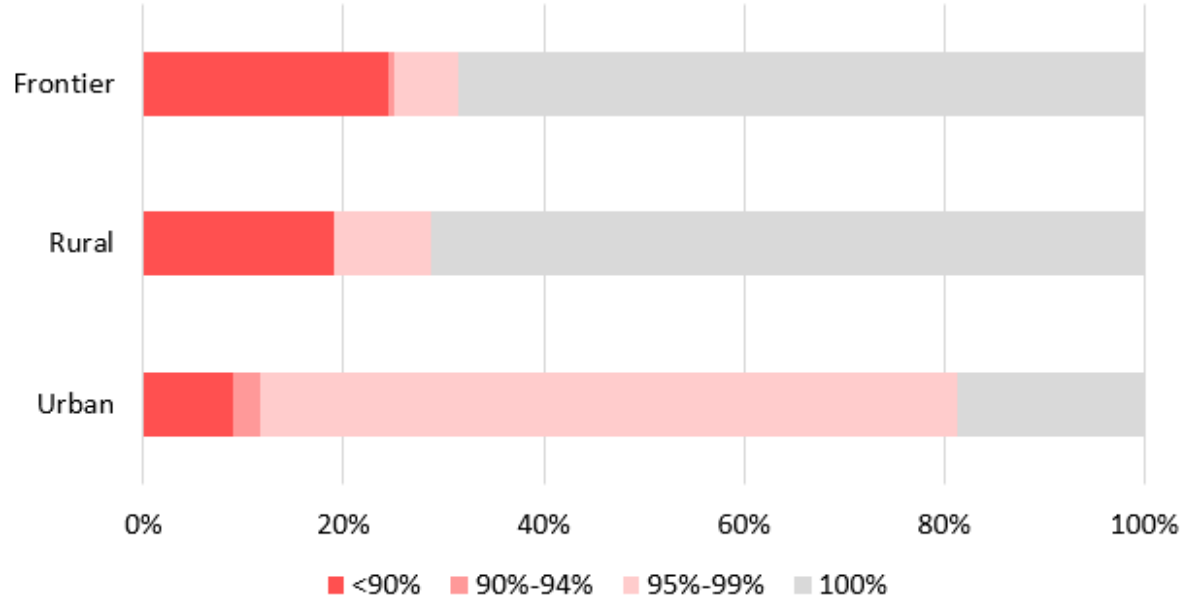


HSAG agreed with 96.9 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 92.8 percent of reported results for rural counties, and 71.4 percent of reported results for urban counties. HSAG disagreed with 3.1 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 7.2 percent of reported results for rural counties, and 28.6 percent of reported results for urban counties.

Access Level Assessment

Figure 4-2 displays the percentage of PH primary care results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for RAE members by urbanicity for FY 2021–2022 Quarter 2.

Figure 4-2—Percentage of Aggregate RAE PH Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021

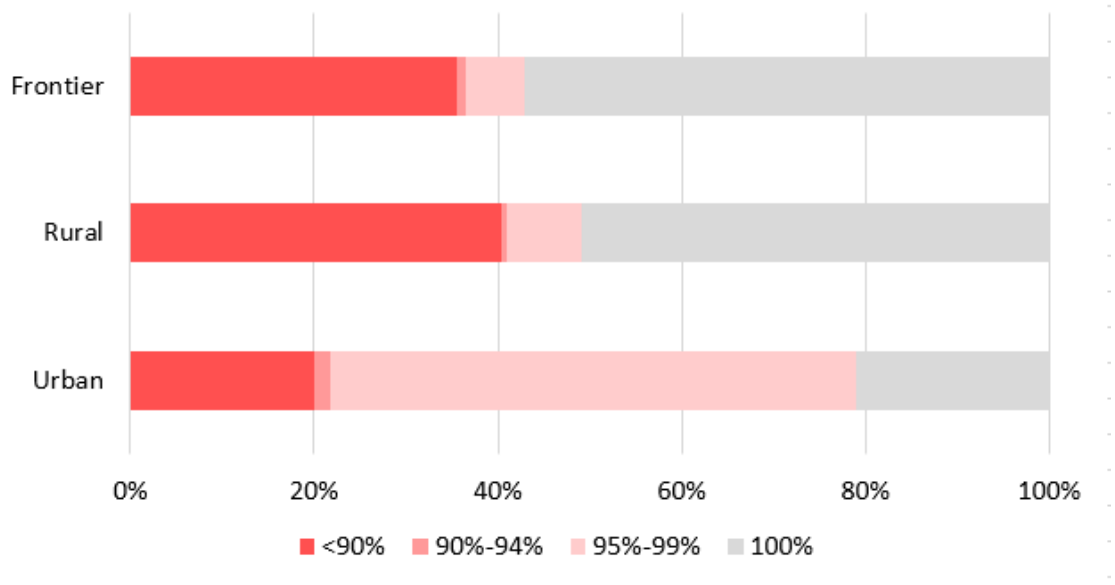


- The first bar in Figure 4-2 reflects a total of 184 PH primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined RAEs are contracted to serve. Of those 184 RAE frontier results, 68.5 percent (n=126) 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 7.1 percent (n=13) 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 24.5 percent (n=45) 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 PH primary care results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined RAEs are contracted to serve. Of those 216 RAE rural results, 71.3 percent (n=154) have 100 percent access level, 9.7 percent (n=21) of the results have 90 to 99 percent access level, and 19.0 percent (n=41) of the results have less than 90 percent access level.

- The third bar in Figure 4-2 reflects a total of 112 PH primary care results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined RAEs are contracted to serve. Of those 112 RAE urban results, 18.8 percent (n=21) have 100 percent access level, 72.3 percent (n=81) of the results have 90 to 99 percent access level, and 8.9 percent (n=10) of the results have less than 90 percent access level.

Figure 4-3 displays the percentage of BH results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for RAE and DHMP members by urbanicity for FY 2021–2022 Quarter 2.

Figure 4-3—Percentage of Aggregate RAE and DHMP BH Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021



- The top bar in Figure 4-3 reflects a total of 299 BH results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined RAEs and DHMP are contracted to serve. Of those 299 RAE and DHMP frontier results, 57.2 percent (n=171) have 100 percent of RAE and DHMP members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 7.4 percent (n=22) 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 35.5 percent (n=106) 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 351 BH results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined RAEs and DHMP are contracted to serve. Of those 351 RAE and DHMP rural results, 51.0 percent

(n=179) have 100 percent access level, 8.6 percent (n=30) of the results have 90 to 99 percent access level, and 40.5 percent (n=142) of the results have less than 90 percent access level.

- The bottom bar in Figure 4-3 reflects a total of 234 BH results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined RAEs and DHMP are contracted to serve. Of those 234 RAE and DHMP urban results, 20.9 percent (n=49) have 100 percent access level, 59.0 percent (n=138) of the results have 90 to 99 percent access level, and 20.1 percent (n=47) of the results have less than 90 percent access level.

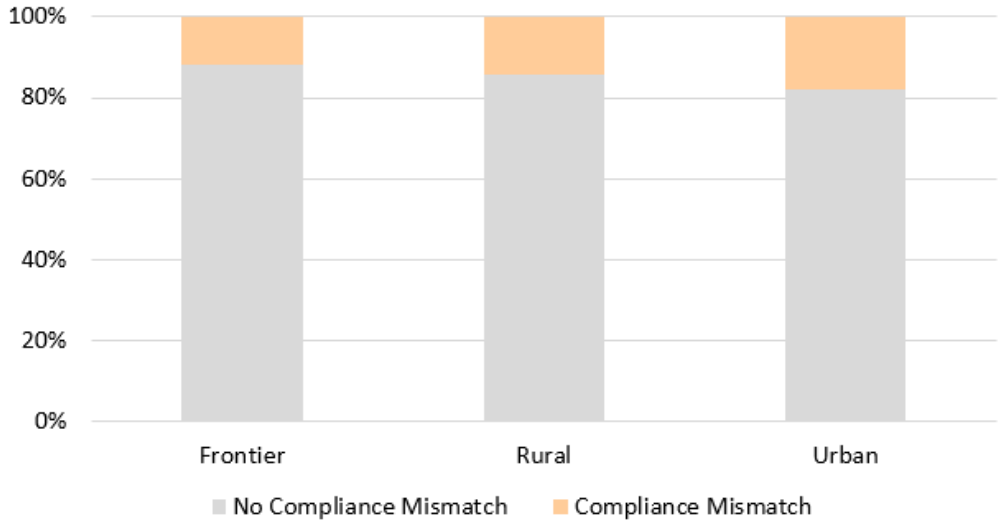
Medicaid Managed Care Organizations

This section summarizes the FY 2021–2022 NAV findings specific to the two Medicaid MCOs (DHMP and RMHP Prime). NAV results for DHMP's minimum time and distance BH requirements are also included in the RAEs' aggregated BH results because DHMP is contracted to provide BH care 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



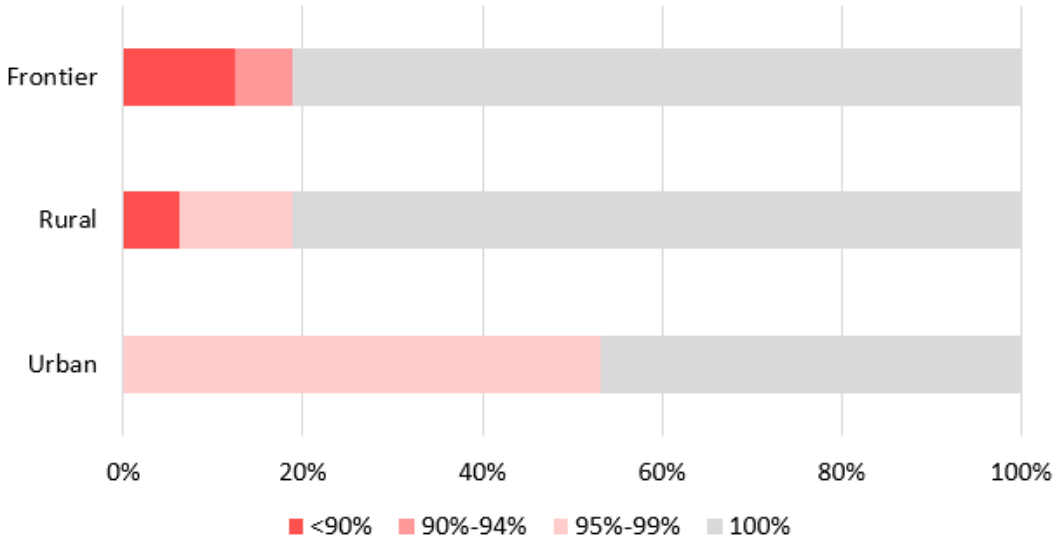
HSAG agreed with 88.3 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 85.8 percent of reported results for rural counties, and 82.0 percent of reported results for urban counties. HSAG disagreed with 11.7 percent of the Medicaid MCOs' reported

quarterly geoaccess compliance results for frontier counties, 14.2 percent of reported results for rural counties, and 18.0 percent of reported results for urban counties.

Access Level Assessment

Figure 4-5 displays the percentage of PH primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for Medicaid MCO members by urbanicity for FY 2021–2022 Quarter 2.

Figure 4-5—Percentage of Aggregate MCO PH Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021



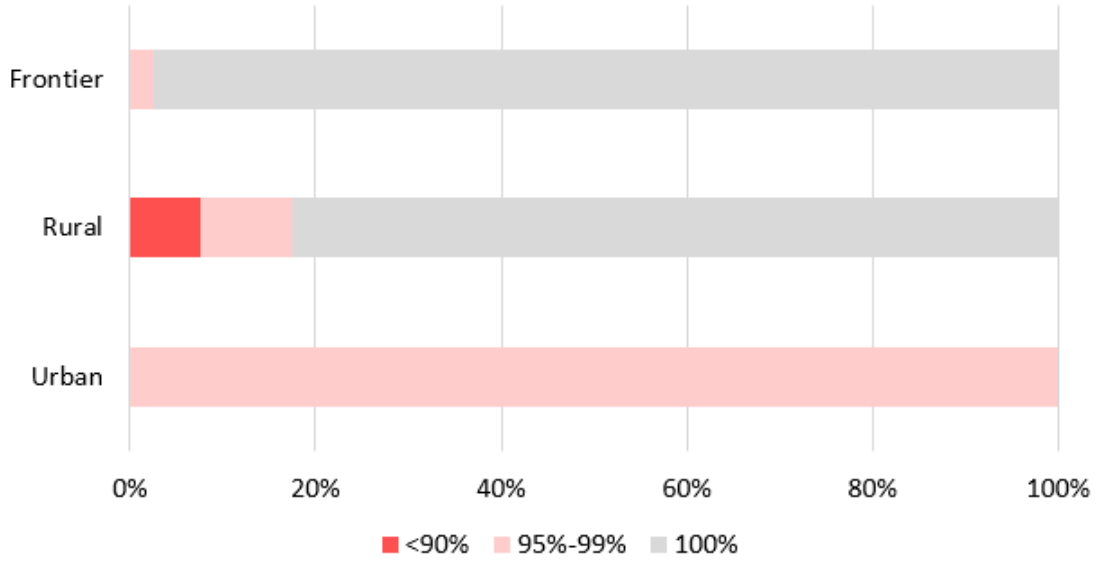
- The top bar in Figure 4-5 reflects a total of 16 PH primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined Medicaid MCOs are contracted to serve. Of those 16 Medicaid MCO frontier results, 81.3 percent (n=13) have 100 percent of Medicaid 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 12.5 percent (n=2) 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 PH primary care results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined Medicaid MCOs are contracted to serve. Of those 32 Medicaid MCO rural results, 81.3

percent (n=26) have 100 percent access level, 12.5 percent (n=4) of the results have 90 to 99 percent access level, and 6.3 percent (n=2) of the results have less than 90 percent access level.

- The bottom bar in Figure 4-5 reflects a total of 32 PH primary care results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined Medicaid MCOs are contracted to serve. Of those 32 Medicaid MCO urban results, 46.9 percent (n=15) have 100 percent access level and 53.1 percent (n=17) of the results have 90 to 99 percent access level.

Figure 4-6 displays the percentage of PH specialist requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of Medicaid MCO members with access in the minimum network requirement by urbanicity for FY 2021–2022 Quarter 2.

Figure 4-6—Percentage of Aggregate MCO PH Specialist Results Within the Time and Distance Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021

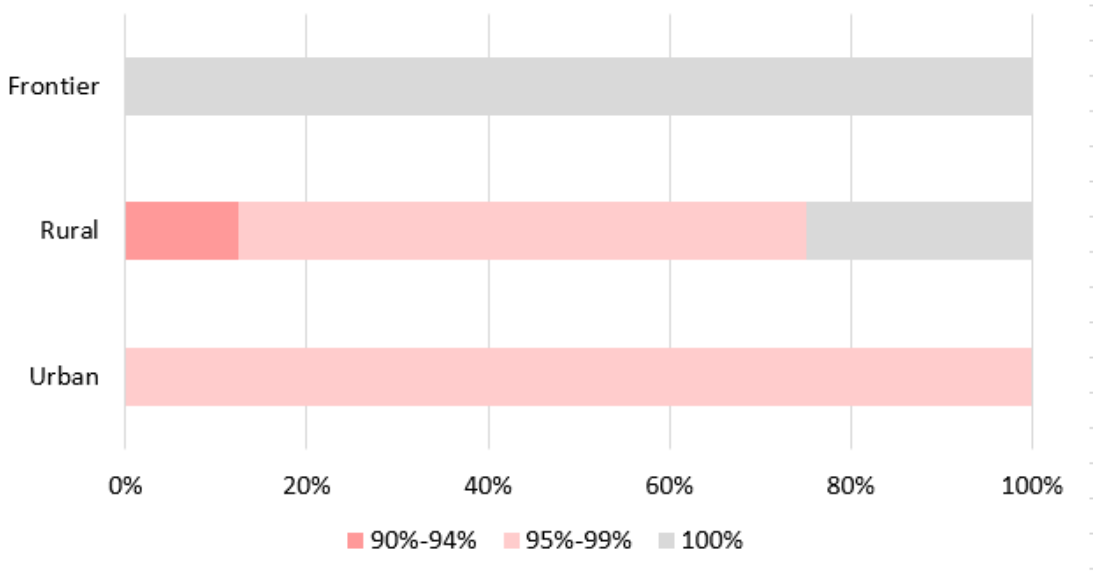


- The top bar in Figure 4-6 reflects a total of 40 PH specialist results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined Medicaid MCOs are contracted to serve. Of those 40 Medicaid MCO frontier results, 97.5 percent (n=39) have 100 percent of Medicaid 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).

- The middle bar in Figure 4-6 reflects a total of 80 PH specialist results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined Medicaid MCOs are contracted to serve. Of those 80 Medicaid MCO rural results, 82.5 percent (n=66) have 100 percent access level, 10.0 percent (n=8) of the results have 90 to 99 percent access level, and 7.5 percent (n=6) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-6 reflects a total of 80 PH specialist results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined Medicaid MCOs are contracted to serve. Of those 80 Medicaid MCO 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 PH entity network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of Medicaid MCO members with access in the network requirement by urbanicity for FY 2021–2022 Quarter 2.

Figure 4-7—Percentage of Aggregate MCO PH Entity Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021



- The top bar in Figure 4-7 reflects a total of four PH entity results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined Medicaid MCOs are contracted to serve. Of those four Medicaid MCO frontier results, 100 percent (n=4) have 100 percent of Medicaid 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 PH entity results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined Medicaid MCOs are contracted to serve. Of those eight Medicaid 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 PH entity results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined Medicaid MCOs are contracted to serve. Of those eight Medicaid 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 2021–2022 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 2021–2022 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
Medicaid MCO	88.3%	85.8%	82.0%
RAE	96.9%	92.8%	71.4%

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:

Various factors associated with the FY 2021–2022 NAV may affect the validity or interpretation of the results presented in this report, including, but not limited to, the following analytic considerations and data-related caveats:

- HSAG validated the MCEs' self-reported time and distance geoaccess compliance results, reflecting the network categories and corresponding practitioner, practice site, or entity attributions.
  - Each MCE's network may include practitioners, practice sites, and entities that support additional healthcare services covered by Colorado's Health First Colorado or CHP+ programs.
  - The MCEs must demonstrate that 100 percent of their members reside within the minimum network requirements to be found in compliance with the network contract requirements. As a result, an MCE's failure to meet a time and distance network requirement does not necessarily equate to a network concern, and the MCE may have alternate methods of ensuring members' access to care (e.g., the use of telehealth or mail-order pharmacy services).
- NAV findings are associated with the MCEs' network data files for all practitioners, practice sites, and entities active with each MCE as of December 31, 2021, and are contingent on the quality of member and network data supplied by the MCEs. Any substantial and systematic errors in the MCEs' member data, network data, and/or geoaccess compliance reporting submissions may compromise the validity and reliability of the FY 2021–2022 NAV results, including the following detailed considerations:
  - NAV results do not reflect the MCEs' network changes implemented since January 2022.
  - HSAG and the Department directed the MCEs to use the Department-approved Network Crosswalk from September 2021 when preparing network data. A lack of compliance

identified during the NAV analyses may reflect either a lack of contracted practitioners, practice sites, or entities for the specified MCE, or an MCE's challenges in aligning internal network data with the Department-approved Network Crosswalk categories.

  - For alignment with the MCEs' geoaccess compliance reports, HSAG primarily used the member county attributions noted in the MCEs' data for the NAV analyses. If an MCE's data were missing the member's county, HSAG used the Quest Analytics Suite to identify the member's county of residence for records with an exact address match to the geocoding resource (i.e., the address could be matched to a specific latitude and longitude). Consistent with the Department's instructions to the MCEs, HSAG's NAV analyses applied the rural minimum network requirements to the urban counties with rural areas (i.e., Larimer, Mesa, and Park counties).
  - HSAG's NAV analyses used members' residential addresses and network service addresses as supplied in the MCEs' data, and addresses may not reflect members' actual place of residence or service locations available to offer on-site services.
  - It was beyond the FY 2021–2022 NAV scope to evaluate the accuracy of the MCEs' network data against an external requirement (e.g., using telephone survey calls to verify the accuracy of network locations, contact information, new patient acceptance, or services offered).

- The time and distance calculations reflected in the FY 2021–2022 NAV represent a high-level measurement of the similarity of the geographic distribution of network locations relative to members. These 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 or CHP+ programs.
  - It is likely that network locations are contracted to provide services for more than one MCE. As such, time and distance results highlight the geographic distribution of a network for all available network locations noted in the MCEs' network data files, without considering potential barriers to new patient acceptance or appointment availability at individual service locations.
  - Prior to calculating time and distance results, HSAG geocoded the MCEs' network and member data to assign latitude and longitude values to each record. A limited percentage of records could not be geocoded and were subsequently excluded from the NAV analyses.
  - The MCEs' address data may not always reflect a member's place of residence (e.g., use of post office boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

Promising Practices and Opportunities for Improvement

Based on the FY 2021–2022 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 MCEs' 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. In FY 2021–2022, HSAG introduced the NADIV process and data display dashboard to enhance the thoroughness of quarterly data quality review. The NADIV dashboard provides an assessment of missing and invalid values in submitted network adequacy data files and makes comprehensive, interactive initial data quality results on network standard compliance directly accessible to the MCEs and the Department.
  - The MCEs' network data quality could be further enhanced by cross-referencing against the Department's *interChange* data[4-3] to confirm MCE practitioner network NPIs, practitioner identification values, practitioner addresses, and taxonomy codes to determine the extent to which each MCE's network aligns with the practitioner/practice site/entities enrolled in *interChange*.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the MCEs' networks through the development and implementation of standardized quarterly network adequacy reporting materials. HSAG performed analysis comparing current and alternate minimum network requirements to evaluate the appropriateness of the minimum network requirements in the MCEs' contracts with the Department. HSAG provided the results of this analysis in the CANVAS web-based dashboard, which reflected the impact of changing minimum network requirements by MCE.

  During FY 2021–2022, the Department and HSAG collaborated to generate draft versions of a formal network exception policy and request templates. The Department may consider continuing the development and implementation of these materials to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards. Future enhancements may include, but are not limited to, the following:
  - The Department may consider the extent to which the MCEs offer alternate service delivery mechanisms to ensure members' access to care when minimum network requirements may not be the most appropriate method of measuring access for certain geographic areas and/or network categories. For example, the Department may consider the extent to which an MCE

[4-3] *interChange* is the Department's MMIS. All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs. While *interChange* offers a direct alignment with the Network Crosswalk for selected network categories, not all network categories are directly identified from the *interChange* data fields.

offers and ensures that members are able to use telehealth modalities to obtain BH services when practitioners are not available in rural or frontier counties.

  - The Department may consider the incorporation and utilization of claims and encounter data in its assessment of network adequacy based on population need. The current network standards apply time and distance standards based on different practitioner types, but may not capture the full picture of network adequacy to meet the needs of the population. The use of historical claims and encounter data to identify historic population needs and utilization, and applying the knowledge to the development of standards that more closely align with population needs would provide the Department, the MCEs, and Medicaid members with networks better structured to provide appropriate and adequate care. Additionally, the Department may consider establishing other alternative metrics for measuring population need and determining network adequacy based on need that may be applied to future assessment and adjustment of network adequacy standards.

- **Expand Network Adequacy Assessment**: To further assess network adequacy, the Department may integrate specified data review topics into network adequacy analysis and an expansion of the NAV dashboard to reflect specific initiatives and goals. Future expansions may include, but are not limited to, the following:
  - In addition to the number of practitioners accepting Medicaid members, the Department may consider asking the MCEs to submit practitioner panel capacity data indicating the number of Medicaid members they are able or willing to accept for treatment to better assess the adequacy of the network in meeting healthcare needs for enrolled Medicaid members. While the geographic distribution of practitioners is assessed through time and distance standards, the analysis does not account for whether or not those practitioners have the capacity to serve the number of Medicaid members in the respective catchment areas. Further consideration of practitioner panel capacity would allow for a better understanding of network adequacy in terms of capacity to serve members.
  - When analyzing network adequacy, it is important to consider that the list of network practitioners' physical locations may not accurately or completely represent an enrolled member's access to services. The Department may consider conducting additional analyses such as using claims and encounter data to identify which of the MCEs' network of practitioners are actively providing services to members during the measurement period. To the extent that contracted practitioners are not actively serving Medicaid members, the time and distance analyses based on the list of contracted practitioners may not be an accurate reflection of the network as experienced by Medicaid members. Future access to care evaluations may incorporate the MCEs' claims and encounter data to assess members' utilization of services and potential gaps in access to care associated with inactive practitioners in the network.
  - The Department may consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population need. To the extent that current network standards take into account the population need for different practitioner types, the standards

may not capture the full picture of network adequacy to meet the needs of the population. The use of historical claims and encounter data to identify population needs and utilization, and application of that knowledge to the development of standards that more closely align with population needs would provide the Department, the MCEs, and Medicaid members with networks better structured to provide appropriate and adequate care. Additionally, the Department may establish alternative metrics for measuring population need and determining network adequacy based on need that may be applied to future assessment and adjustment of network adequacy standards.

Encounter Data Validation—RAE 411 Over-Read

Statewide Results

Table 4-7 presents the RAEs' (which includes DHMP's 411 results) self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-7—FY 2021–2022 RAEs' Aggregated, Self-Reported EDV Results by Data Element and BH Service Category

Data Element	Inpatient Services (1,096 Cases)	Psychotherapy Services (1,096 Cases)	Residential Services (1,096 Cases)
Procedure Code	NA	82.8%	90.0%
Principal Surgical Procedure Code	97.3%	NA	NA
Diagnosis Code	85.8%	86.7%	89.5%
Place of Service	NA	75.1%	85.6%
Service Category Modifier	NA	83.4%	89.6%
Units	NA	90.9%	90.8%
Revenue Code	93.5%	NA	NA
Discharge Status	88.5%	NA	NA
Service Start Date	94.3%	92.3%	91.3%
Service End Date	96.1%	92.4%	91.1%
Population	NA	92.2%	91.4%
Duration	NA	88.6%	91.1%
Staff Requirement	NA	88.3%	90.5%

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' (which includes DHMP's 411 results) 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 (80 Over-Read Cases)	Psychotherapy Services (80 Over-Read Cases)	Residential Services (80 Over-Read Cases)
Procedure Code	NA	98.8%	93.8%
Principal Surgical Procedure Code	100%	NA	NA
Diagnosis Code	98.8%	95.0%	93.8%
Place of Service	NA	93.8%	95.0%
Service Category Modifier	NA	97.5%	93.8%
Units	NA	NA	95.0%
Revenue Code	100%	NA	NA
Discharge Status	98.8%	NA	NA
Service Start Date	95.0%	96.3%	95.0%
Service End Date	96.3%	96.3%	95.0%
Population	NA	97.5%	95.0%
Duration	NA	97.5%	95.0%
Staff Requirement	NA	95.0%	95.0%

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 2021–2022 is the third 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' and DHMP's independent validation findings accurately reflect their encounter data quality, with the exception of inpatient services cases, specifically the *service start date* encounter data element.

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, HSAG recommends that the RAEs 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 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—FY 2021–2022 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	95.6%	86.9%	77.7%	94.7%	88.7%
Through Date	96.1%	NA	NA	NA	96.1%
Diagnosis Code	92.7%	80.6%	66.0%	88.8%	82.0%
Surgical Procedure Code	96.6%	NA	NA	NA	96,6%
Discharge Status	93.2%	NA	NA	NA	93.2%
Procedure Code	NA	82.5%	66.5%	83.0%	77.3%
Procedure Code Modifier	NA	85.9%	77.2%	91.3%	84.8%
Units	NA	85.0%	76.2%	94.2%	85.1%

** 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—FY 2021–2022 Statewide Aggregated Encounter Over-Read Agreement Results for MCOs by Service Category

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percentage With Complete Agreement	Total Number of Elements	Percentage With Complete Agreement
Inpatient	40	95.0%	240	96.7%
Outpatient	40	92.5%	200	97.5%
Professional	40	100%	200	100%
FQHC	40	90.0%	200	96.0%
Total	**160**	**94.4%**	**840**	**97.5%**

Overall, results from HSAG's FY 2021–2022 MCO 412 EDV over-read showed that HSAG's reviewers agreed with the MCOs' reviewers for 94.4 percent of the over-read cases and 97.5 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 high level of confidence that DHMP's and RMHP Prime's 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' PH encounter data submissions, and verifying that the MCO is routinely monitoring encounter data quality beyond the annual 412 EDV.

CAHPS Surveys—RAEs

Statewide Results

Adult Survey

Table 4-11 shows the adult CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2021–2022.

Table 4-11—FY 2021–2022 Adult Statewide CAHPS Results for RAEs

Measure	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	Colorado RAE Aggregate
Rating of Health Plan	59.6%	56.5%+	54.5%	53.4% ↓	57.4%	59.0%	49.4% ↓	55.2% ↓
Rating of All Health Care	60.8%	53.3%+	59.1%+	51.2%	52.5%+	63.1%+	49.2%+ ↓	56.5%
Rating of Personal Doctor	72.1%	72.7%+	61.2%	65.0%	76.2% ▲	69.7%	56.6% ↓ ▼	66.2%
Rating of Specialist Seen Most Often	71.4%+	72.2%+	67.8%+	65.5%+	69.9%+	67.0%+	71.7%+	69.2%
Getting Needed Care	80.6%+	81.3%+	77.7%+	84.7%+	78.6%+	85.2%+	80.9%+	80.9%
Getting Care Quickly	77.4%+	80.4%+	77.3%+	86.3%+	78.8%+	78.2%+	77.3%+	78.9%
How Well Doctors Communicate	90.6%+	92.2%+	88.8%+	92.7%	94.0%+	91.2%+	92.7%+	91.3%
Customer Service	85.1%+	82.1%+	82.5%+	88.6%+	84.3%+	92.4%+	93.1%+	86.7%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

Child Survey

Table 4-12 shows the child CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2021–2022.

Table 4-12—FY 2021–2022 Child Statewide CAHPS Results for RAEs

Measure	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	Colorado RAE Aggregate
Rating of Health Plan	68.4%	69.3%	73.3%	68.3%	75.6%	71.8%	67.7%	70.8%
Rating of All Health Care	66.1% ↓	64.4%+ ↓	64.1% ↓	56.2% ↓	71.8%	70.5%	63.5% ↓	65.1% ↓
Rating of Personal Doctor	78.8%	78.3%	71.4% ↓	73.7%	84.1% ↑	78.0%	75.7%	76.1%
Rating of Specialist Seen Most Often	59.2%+	64.0%+	71.8%+	76.0%+	75.6%+	87.7%+ ↑	66.4%+	70.9%
Getting Needed Care	77.7%+	75.3%+ ↓	82.6%+	81.0%+	80.4%	91.2%+ ▲	71.5%+ ↓	80.2% ↓
Getting Care Quickly	85.1%+	81.5%+	86.5%+	83.6%+	84.4%+	85.2%+	84.4%+	84.9%
How Well Doctors Communicate	93.2%	95.7%+	91.9%	95.4%	92.7%	95.6%	93.7%	93.6%
Customer Service	83.8%+	82.4%+	88.7%+	82.0%+	89.1%+	85.1%+	86.4%+	86.0%

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*
↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*
▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the Colorado RAE aggregate.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the Colorado RAE aggregate.*

Statewide Conclusions and Recommendations Related to CAHPS

Adult Survey

HSAG found the following:

- The RAE regions had FY 2021–2022 scores that were statistically significantly lower than the 2021 NCQA national averages across the following measures:
  - *Rating of Health Plan*
  - *Rating of All Health Care*

  - *Rating of Personal Doctor*

- Only one RAE region, CCHA Region 7, had a FY 2021–2022 score that was statistically significantly lower than the statewide average score for FY 2021–2022.
- The State's three most rural RAE regions (RAE regions 1, 2, and 4) had one measure score that was statistically significantly lower than the 2021 NCQA national average while the State's most urban RAE regions (RAE regions 5 and 6) had none.

To address these low CAHPS scores, HSAG recommends the Department consider:

- Prioritizing these measures for developing statewide improvement initiatives with performance goals designed to improve member perceptions within the measures.
- Focusing efforts on evaluating key drivers for these measure scores in Colorado's most rural regions.
- Working with the RAEs that received no scores that were statistically significantly lower than the 2021 NCQA national averages in FY 2021–2022 on specific measures to develop and share best practices with other RAEs that show opportunities for improvement for the same measures.

Child Survey

HSAG found the following:

- The RAE regions had FY 2021–2022 scores that were statistically significantly lower than the 2021 NCQA national averages across the following measures:
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
  - *Getting Needed Care*
- The State's three most rural RAE regions (RAE regions 1, 2, and 4) had four measure scores that were statistically significantly lower than the 2021 NCQA national averages while the State's most urban RAE regions (RAE regions 5 and 6) had none.
- COA Region 3, which is considered within the Denver metropolitan area, had two measure scores that were statistically significantly lower than the 2021 NCQA national averages.

To address these low CAHPS scores, HSAG recommends the Department consider:

- Prioritizing these measures for developing statewide improvement initiatives with performance goals designed to improve member perceptions within the measures.

- Focusing efforts on evaluating key drivers for these measure scores in Colorado's most rural regions.
- Working with the RAEs that received no scores that were statistically significantly lower than the 2021 NCQA national averages in FY 2021–2022 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

Adult Survey

Table 4-13 shows the adult Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2021–2022.[4-4]

Table 4-13—FY 2021–2022 Adult Medicaid CAHPS Results for MCOs

Measure	FY 2021–2022 DHMP Score	FY 2021–2022 RMHP Prime Score
Rating of Health Plan	58.6%	58.5%
Rating of All Health Care	52.8%	49.3% ↓
Rating of Personal Doctor	68.9% ▼	61.2% ↓
Rating of Specialist Seen Most Often	70.6%	71.1%+
Getting Needed Care	71.7% ↓ ▼	83.6%
Getting Care Quickly	71.3% ↓	80.2%
How Well Doctors Communicate	92.1%	87.4% ↓
Customer Service	87.9%	88.7%+

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

[4-4] 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.

Child Survey

Table 4-14 shows the child Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2021–2022.[4-5]

Table 4-14—FY 2021–2022 Child Medicaid CAHPS Results for MCOs

Measure	FY 2021–2022 DHMP Score	FY 2021–2022 RMHP Prime Score
Rating of Health Plan	72.3%	68.7%
Rating of All Health Care	70.7%+	63.2% ↓ ▼
Rating of Personal Doctor	82.3%	69.4% ↓
Rating of Specialist Seen Most Often	87.5%+	79.6%+
Getting Needed Care	80.2%+	85.4%
Getting Care Quickly	82.1%+	87.5%
How Well Doctors Communicate	93.7%+	96.8% ↑
Customer Service	89.6%+	89.1%+

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 2021–2022 score is statistically significantly higher than the 2021 NCQA national average.*

↓ *Indicates the FY 2021–2022 score is statistically significantly lower than the 2021 NCQA national average.*

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

Statewide Conclusions and Recommendations Related to MCO CAHPS

Adult Survey

The following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the 2021 NCQA national averages:

- *Getting Needed Care* 🔑
- *Getting Care Quickly* ⏱️

The following measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the FY 2020–2021 scores:

- *Rating of Personal Doctor*

[4-5] 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.

- *Getting Needed Care*

The following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

None of the measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the FY 2020–2021 scores.

To address the low CAHPS scores, HSAG recommends the Department consider:

- Working with the MCOs to determine what may be driving low scores by adult members for these measures. This could include:
  - Conducting a root cause analysis to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies.
  - Performing an assessment of UR turnaround times and of care coordination processes.
- Collaborating with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of the quality of, timeliness of, and access to care for adults enrolled in Medicaid.

Child Survey

None of the measures' FY 2021–2022 scores for DHMP were statistically significantly lower than the 2021 NCQA national averages or the FY 2020–2021 scores.

The following measures' FY 2021–2022 scores for RMHP Prime were statistically significantly lower than the 2021 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

The following measure's FY 2021–2022 score for RMHP Prime was statistically significantly lower than the FY 2020–2021 score:

- *Rating of All Health Care*

To address the low CAHPS scores, HSAG recommends the Department consider:

- Working with RMHP Prime to determine what may be driving low scores by parents/caretakers of child members for these measures. This could include:
  - Conducting a root cause analysis to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies.
  - Performing an assessment of UR turnaround times and of care coordination processes.
- Collaborating with each MCO to develop initiatives designed to improve processes that may impact parents'/caretakers' perceptions of the QOC for children enrolled in Medicaid.

Quality Improvement Plans

Statewide Results

Table 4-15 presents the FY 2021–2022 RAE 411 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the RAEs.

Table 4-15—Comparative Average Summary of Accuracy Scores for RAEs

Claim Type	Time/Phase	RMHP Region 1	NHP Region 2	COA Region 3	COA Region 5	CCHA Region 6	CCHA Region 7
Inpatient	Baseline	78%	NA	89%	NA	NA	NA
	Month 1	93%	NA	100%	NA	NA	NA
	Month 2	98%	NA	100%	NA	NA	NA
	Month 3	98%	NA	NA	NA	NA	NA
Psychotherapy	Baseline	46%	81%	71%	62%	90%	88%
	Month 1	87%	90%	100%	100%	100%	100%
	Month 2	85%	99%	90%	90%	100%	100%
	Month 3	86%	97%	90%	100%	100%	100%
Residential	Baseline	82%	NA	78%	NA	NA	86%
	Month 1	87%	NA	100%	NA	NA	100%
	Month 2	87%	NA	100%	NA	NA	100%
	Month 3	87%	NA	100%	NA	NA	100%

**Green shading indicates accuracy of 90 percent and higher; red shading indicates accuracy less than 90 percent.*

NA indicates the health plan did not have baseline scores under 90 percent; therefore, no comparisons can be made.

COA Region 3's inpatient pilot partner was closed during January 2022 due to the Marshall Fire in Colorado; therefore, only claims from November 2021 and December 2021 were included in this QUIP.

HCI did not self-identify any scoring under 90 percent accuracy; therefore, HCI did not participate in the QUIP during FY 2021–2022. CCHA Region 6 ambulatory inpatient data were not aggregated with other health plan inpatient data due to an inconsistency with CCHA Region 6's sampling approach for inpatient services.

For the two health plans that focused on inpatient claim types in the QUIP, both demonstrated an increase from baseline scores by the end of the QUIP (or in COA Region 3's case, month two). All six of the health plans who focused on psychotherapy claims reported improved accuracy from baseline scores, although RMHP still remained below the 90 percent accuracy threshold. The three health plans that focused on residential claims each reported improvement from baseline by the end of the QUIP, although again RMHP still remained 3 percentage points below the 90 percent accuracy threshold.

Table 4-16 presents the FY 2021–2022 MCO 412 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the MCOs.

Table 4-16—Comparative Average Summary of Accuracy Scores for MCOs

Claim Type	Time/Phase	RMHP Prime	DHMP
Inpatient	Baseline	77%	NA
	Month 1	99%	NA
	Month 2	100%	NA
	Month 3	92%	NA
Outpatient	Baseline	88%	87%
	Month 1	95%	100%
	Month 2	100%	100%
	Month 3	100%	100%
Professional	Baseline	76%	78%
	Month 1	99%	19%
	Month 2	99%	49%
	Month 3	100%	61%
FQHC	Baseline	70%	81%
	Month 1	97%	90%
	Month 2	97%	80%
	Month 3	97%	75%

**Green shading indicates accuracy of 90 percent and higher; red shading indicates accuracy less than 90 percent.*

NA indicates the MCE did not have baseline scores under 90 percent; therefore, no comparisons can be made.

All four of RMHP Prime's claim types showed an outcome resulting in increased data accuracy, whereas only one of DHMP's three claim types showed improved data accuracy by the end of the FY 2021–2022 412 MCO QUIP.

Statewide Conclusions and Recommendations Related to the QUIP

As a universal observation, the results indicate that each of the RAEs and MCOs experienced improvements, to some extent, due to the interventions implemented for this QUIP.

- For Medicaid health plans statewide—both the RAEs and MCOs—the most common opportunities for improvement were the following:
  - Obtaining records from providers for the 411 or 412 audits, EHR limitations, and documentation not meeting minimum requirements.
  - Recurring low accuracy scores for specific procedure codes across EDV and QUIP projects.
  - Some MCEs reported communication barriers and inconsistencies in pilot provider participation throughout the QUIP.
- For Medicaid health plans statewide—both the RAEs and MCOs—HSAG recommends the following:
  - Continuing to conduct provider and agency chart audits to identify specific and recurrent issues, specifically regarding telehealth. Address provider noncompliance by instituting CAPs to ensure providers are delivering complete medical records on time, in compliance with contract and professional expectations. Offer periodic, targeted trainings for common errors and communicate coding updates via website postings, provider newsletters, and email communications.

Mental Health Parity Audits

Statewide Results

Table 4-17—MHP Audit Statewide Results for RAEs and MCOs

MCE	Region	FY 2020–2021 Total Score	Category of Service	Compliance Score	FY 2021–2022 Total Score
RAEs—MH/SUD Services					
RMHP	1	100%	Inpatient	86%	91%∨
			Outpatient	96%	
NHP	2	98%	Inpatient	100%	98%~
			Outpatient	94%	
COA Region 3	3	100%	Inpatient	100%	100%~
			Outpatient	100%	
HCI	4	99%	Inpatient	96%	94%∨
			Outpatient	88%	
COA Region 5	5	98%	Inpatient	99%	99%∧
			Outpatient	100%	
CCHA Region 6	6	84%	Inpatient	82%	86%∧
			Outpatient	91%	
CCHA Region 7	7	83%	Inpatient	78%	81%∨
			Outpatient	84%	
MCOs—MH/SUD and M/S Services					
DHMP		100%	Inpatient	99%	97%∨
			Outpatient	96%	
RMHP Prime		100%	Inpatient	87%	89%∨
			Outpatient	91%	

∨ *Indicates that the score declined as compared to the previous review year.*
∧ *Indicates that the score increased as compared to the previous review year.*
~ *Indicates that the score remained unchanged as compared to the previous review year.*

Statewide Conclusions and Recommendations Related to the MHP Audit

Based on the MHP Audit results in FY 2021–2022, the MCEs demonstrated compliance and opportunities for improvement in many areas. Most (five or more) MCEs statewide—both the RAEs and MCOs:

- Used nationally recognized UR criteria. MCG UR criteria and InterQual UR criteria were often used for MH determinations and ASAM level of care criteria were used for SUD determinations.
- Ensured consistency and quality of UM decisions by requiring UM staff members to participate in IRR testing annually and requiring a passing score of 80 or 90 percent.
- Demonstrated policies and procedures that described an appropriate level of expertise required for UM staff members making denial determinations. Additionally, most health plans demonstrated consistent documentation in the files regarding the individual who made the determination.
- Utilized a Department-approved NABD template letter that included the required information and notified members of their right to an appeal.

For Medicaid health plans statewide—both the RAEs and MCOs—the most common opportunities for improvement were the following:

- Most health plans were out of compliance for timeliness in regard to sending NABDs within some of the records reviewed, despite having accurate policies and procedures. HSAG recommends the Department and health plans work together to develop and implement ongoing staff training and monitoring to ensure adherence to Colorado-specific timelines.
- The health plans demonstrated instances in which the peer-to-peer review with the requesting provider was not adequately documented in the electronic documentation system. HSAG recommends the Department and health plans evaluate documentation protocols to ensure accuracy of documenting whether peer-to-peer reviews are offered.
- The NABDs sent by the health plans did not always include the Department's best practices regarding reason and rationale. HSAG recommends the Department implement ongoing monitoring to assess the health plans' compliance with the use of the Department's templates and best practices for communicating NABDs with members.

Quality of Care Concern Audit

Five different QOC definitions were used by the MCEs. Table 4-18 summarizes each MCEs' definition.

Table 4-18—Definitions Used by the MCEs

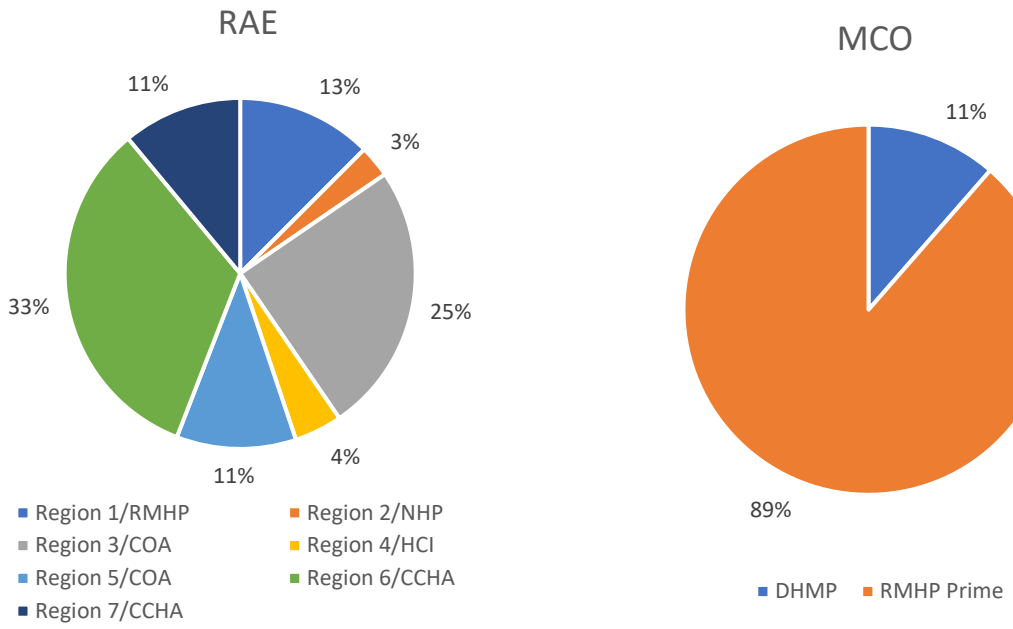
RMHP and RMHP Prime
"A quality-of-care grievance is a type of grievance that is related to whether the quality of covered services provided by the health plan or provider meets professionally recognized standards of health care including whether appropriate health care services have been provided or have been provided in appropriate settings. Examples of a quality-of-care grievance include any instances where an enrollee infers or state they believe: • They were mis-diagnosed; • Treatment was not appropriate; and/or • They received, or did not receive, care that adversely impacted or had the potential to adversely impact their health."[4-6]
NHP and HCI
"Any action or failure to take action on the part of a provider that the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk."
COA (Regions 3 and 5) and DHMP (BH)
"A complaint made about a provider's competence, conduct, and/or care provided that could adversely affect the health or welfare of a member."
CCHA (Regions 6 and 7)
"Quality of care issues include potential, suspected, and realized events that may or may not have resulted in harm incurred by member(s)."
DHMP (PH)
"Any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which would adversely affect the health and/or welfare of a member. QOC complaints include serious reportable adverse events (SRAEs), never events (NEs), and hospital acquired conditions (HACs)."

[4-6] 42 CFR §422.564(e)(2) or §423.564(e)(2). Parts C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance 30.3 Quality of Care Grievances, Effective January 1, 2020. Available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf. Accessed on: Oct 28, 2022.

Table 4-19—Number of Substantiated Cases

	RAE							MCO	
	Region 1RMHP	Region 2 NHP	Region 3 COA	Region 4 HCI	Region 5 COA	Region 6 CCHA	Region 7 CCHA	DHMP	RMHP Prime
# of Substantiated Cases	17	4	34	6	15	45	15	4	31
Totals	**136**							**35**	

Figure 4-8—Percentage of Substantiated Cases



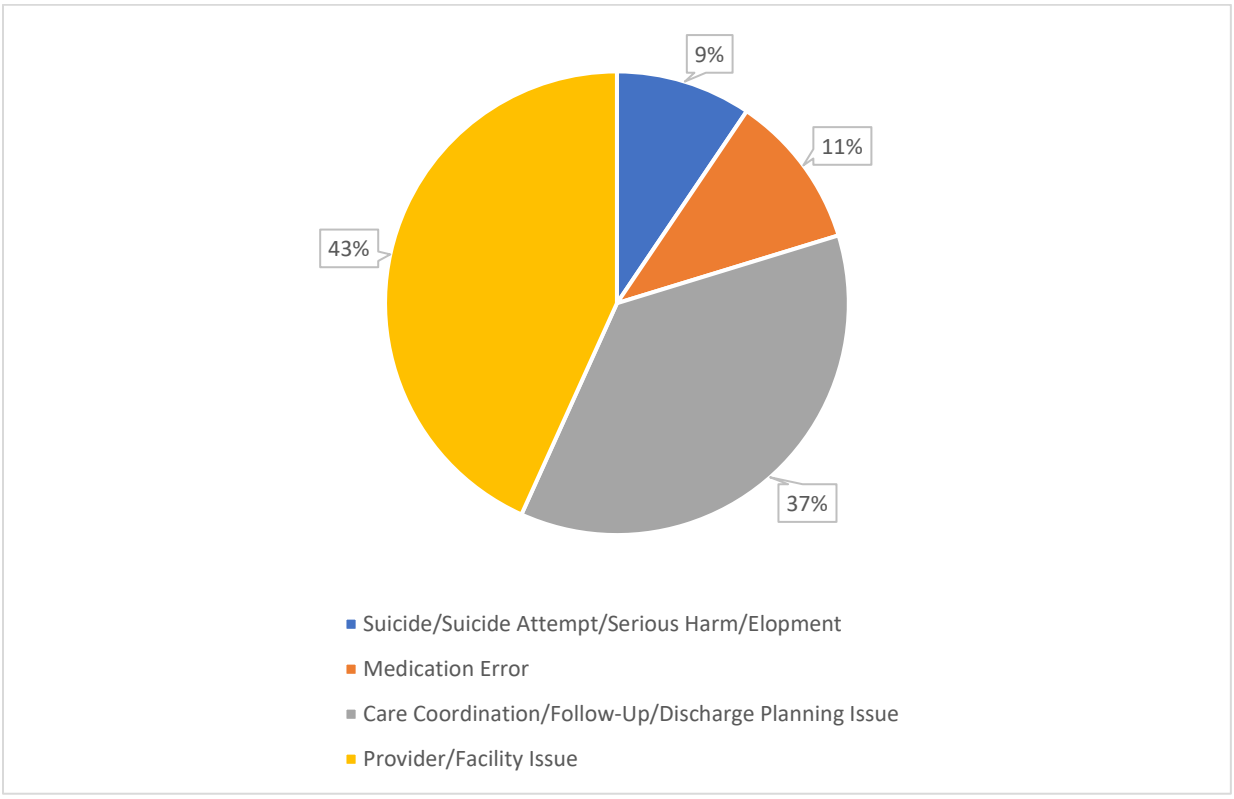
Collectively, the MCEs used professionals with the following qualifications and/or degrees to investigate:

- Master's degree
- BH clinician
- Licensed clinical social worker
- Nurse
- Medical director
- Psychiatrist
- Quality experience

- Certified professional in healthcare quality (CPHQ)
- Licensed clinical staff members

HSAG used the MCEs' categorization of each substantiated QOCG and developed overarching categories to provide a summary of QOCG topics in the case sample population, which is provided in Figure 4-9.

Figure 4-9—Percentage of Case Types



HSAG referenced the MCEs' severity rating levels and created overarching category levels (low, moderate, and high) to provide an overarching view of the case sample population and severity of cases reviewed. The severity level percentages are presented in Figure 4-10.

Figure 4-10—Severity Level Percentages

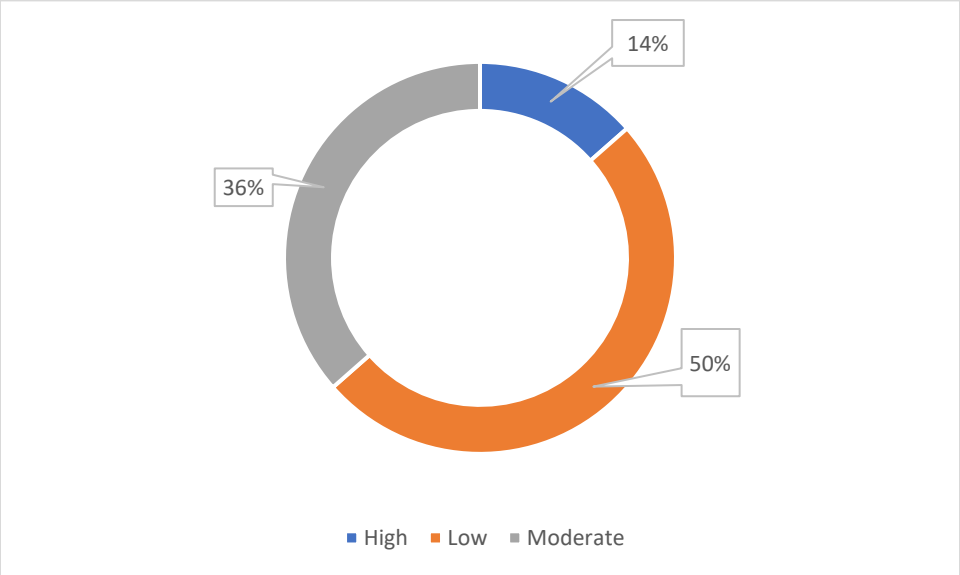


Figure 4-11 through Figure 4-14 provide a statewide summary for the 74 sample cases reviewed in the areas of case outcomes, members' race and ethnicity, and disability status.

Figure 4-11—Case Outcome

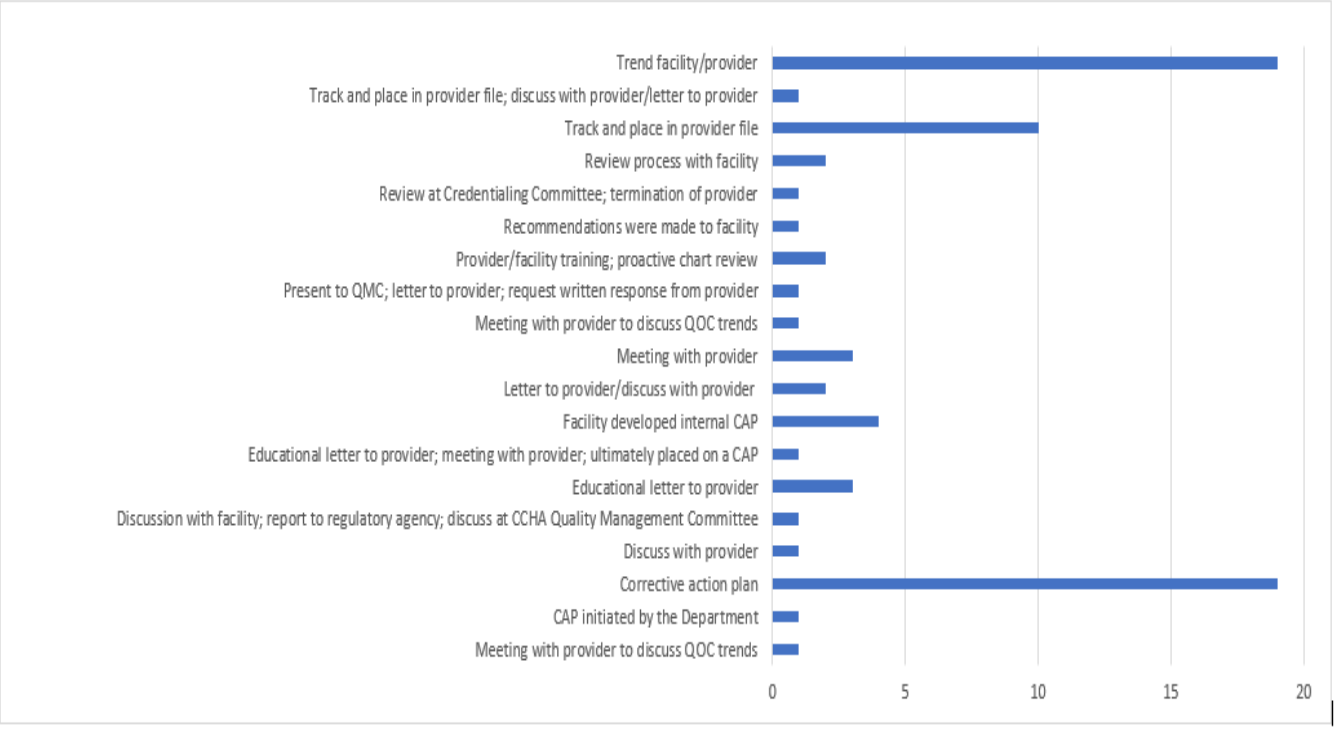


Figure 4-12—Count of Member's Race

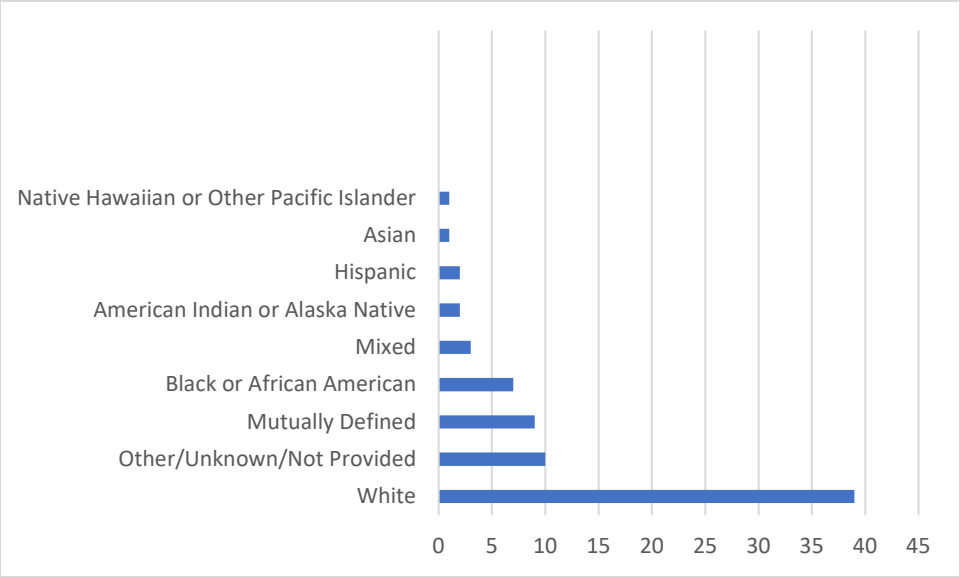


Figure 4-13—Percentages of Members by Ethnicity

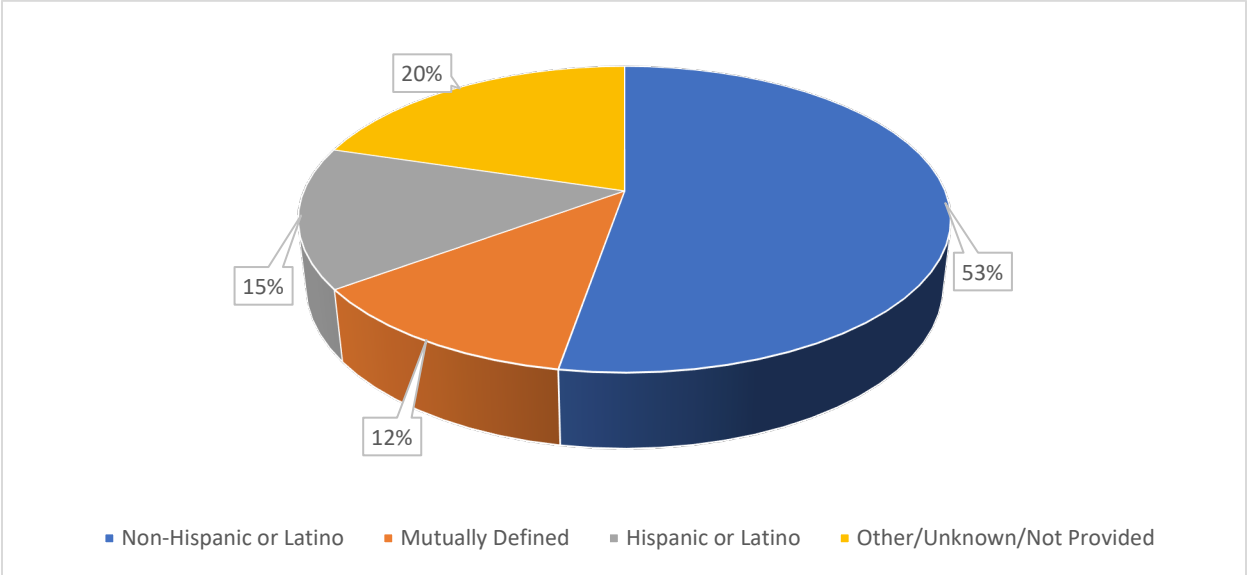
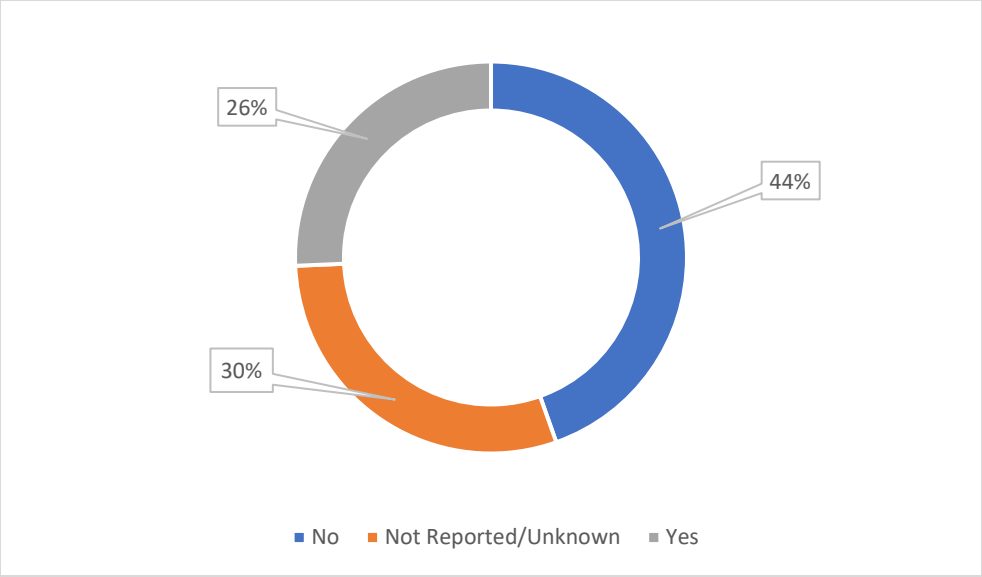


Figure 4-14—Percentages of Disabled Members



All MCEs had a system for identifying and addressing all alleged QOCGs. When a concern was raised, the MCEs investigated, analyzed, tracked, trended, and resolved QOCGs according to their MCE-specific policy.

Based on the review of all sample cases and associated documents from each MCE, HSAG determined that each MCE (all RAEs, RMHP Prime, and DHMP [BH]) adhered to its internal policies and procedures. HSAG was unable to evaluate whether DHMP (PH) adhered to its internal policies and procedures because the MCE did not report any substantiated QOCGs during the review period.

The MCEs used four different level rating systems to define the severity of QOCGs. Additionally, DHMP used a finding determination for its PH QOC complaints. Table 4-20 summarizes each MCE's definition.

Table 4-20—Rating/Finding Definition by MCE

RMHP and RMHP Prime	
Rating	**Definition**
No issue	No quality of care issue defined
Minor	A minor departure from the standard of care with a low likelihood of a potential serious adverse outcome
Moderate	A moderate departure from the standard of care with moderate likelihood of a potential serious adverse outcome
Severe	A serious departure from the standard of care with a high likelihood of a potential serious adverse outcome

NHP and HCI	
Rating	**Definition**
Not an incident	Not an incident
Minimal	Minimal risk, or potential risk, to safety
Moderate	Moderate risk, or potential risk, to safety
Major	Actual or potential life threatening injury, though not catastrophic
Sentinel	Actual harm to member that is considered catastrophic and involves injury, threat of major or permanent loss of physical or psychological function including death
COA (Regions 3 and 5) and DHMP (BH)	
Rating	**Definition**
0	No quality incident identified
1	Minor or isolated professional incident/no harm to member
2	Care or conduct outside professional standards with potential to cause harm/minimal harm
3	Care or conduct outside professional standards with harm to member (requires an action of corrective action plan)
CCHA (Regions 6 and 7)	
Rating	**Definition**
Level 0	Not a quality of care issue
Level 1	No quality issue substantiated
Level 2	Quality issue—does not impact the care outcome
Level 3	Clear and significant quality issue—does impact the care outcomes
Level 4	Complex and significant quality issue
Level 5	Emergency quality issue—issue raised is egregious
DHMP (PH)	
Finding	**Definition**
Unsubstantiated	No quality of care complaint identified; meets community standard of care
Substantiated	Quality of care complaint identified; does not meet community standard of care
Inconclusive	Quality of care complaint has highlighted areas for improvement, but care provided was not injurious to member

Out of a total of 74 sample cases reviewed across all MCEs:

- 22 cases spanning across all MCEs had a CAP implemented, followed, and monitored until completion.
- One case had a CAP that was initiated, followed, and monitored by the Department.
- Two cases were still in process at the time of this report.

Out of a total of 74 sample cases reviewed across all MCEs, three cases were reported to a regulatory agency as required by policy. Table 4-21 provides details for each MCE in regard to a number of sample cases reviewed that required regulatory agency reporting and whether regulatory agency reporting was described in the respective MCE's policy.

Table 4-21—Regulatory Agency Reporting

	MCO		RAE						
	DHMP	RMHP Prime	Region 1 RMHP	Region 2 NHP	Region 3 COA	Region 4 HCI	Region 5 COA	Region 6 CCHA	Region 7 CCHA
Number of sample cases reviewed that required regulatory agency reporting	0 out of 4 (for BH only)	0 out of 10	0 out of 10	0 out of 4	0 out of 10	1 out of 6	1 out of 10	0 out of 10	1 out of 10
Regulatory agency reporting described in policy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Statewide Conclusions and Recommendations Related to QOCC Audit

- Each MCE had developed internal policies, procedures, and/or desk protocols to address potential issues with QOC and recognized the importance of having a process for handling these concerns. The MCEs had various definitions categorizing QOC issues/concerns and used terms such as "grievance," "issue," "concern," and "complaint" when describing the process.
- Statewide inconsistencies were identified throughout the following:
  - Policies/procedures/desk protocols
  - Definitions
  - Severity levels
  - Qualifications of staff members investigating
  - CAP reporting
  - Regulatory agency reporting
  - Timeline for completing investigations
  - Staff and provider training
  - Letter/form templates
  - Process for provider/facility to report
  - Tracking/trending/monitoring
  - Referral to a credentialing committee, peer review committee, and other applicable committees
  - Acknowledgment and resolution letter notifications

  - Reporting mechanisms to the Department
  - Expectations and reporting instructions for providers
  - Variations with the number of substantiated QOCGs
- Despite the inconsistencies, the MCEs emphasized that member safety is accorded the highest priority.

HSAG recommended the MCEs consider:

- Assessing and revising policies and procedures related to QOCCs to ensure that all investigation and documentation steps are included.
- Developing and implementing staff and provider training modules and requiring staff and providers to access the training modules at regular intervals (i.e., quarterly, semiannually). Training could be an effort to bring awareness for internal staff/providers to report potential QOCCs.
- Developing and implementing tracking systems within each MCE's documentation system that ensure standardized steps taken to investigate QOCCs; ensure consistent follow-up on any corrective actions required or self-imposed by providers; and allow trending to review patterns regarding providers, diagnoses, service types, etc.
- Incorporating QOCC trending information into the QAPI Committee review for QOC improvement purposes.
- Consistently referring QOCC issues that are provider-specific to the Credentialing Committee for consideration during recredentialing processes.
- Developing and implementing policies and procedures to ensure that the originator/reporter of the original potential concern receives an acknowledgement and resolution letter.
- For investigations that originated following a QOCG from the member, ensuring that the member receives an acknowledgement and resolution letter consistent with the grievance process at 42 CFR §438.400 (addressing member-specific resolution such as having changed the provider, or working with the member to ensure needs are met).
- Reviewing members' experience as it relates to QOC. A member's experience can stimulate important insights into the kinds of changes that are needed to close the difference between the care that is provided and the care that should be provided.
- Developing reporting procedures and mechanisms to ensure QOCGs are reported to the State as described in the contract.

- Expanding language in the provider agreement and/or provider manual to detail that the provider is expected to inform the member about the complaint process (should speak up about observed QOCG issues and how to submit a QOCG).
- For MCEs with low numbers of documented QOCGs, incorporating additional trainings for member services and care coordination to identify QOCGs, report, document, and follow-up with the responsible internal departments.
- Streamlining the process of acknowledgment and resolution notifications with the grievance process wherever appropriate.
- Integrating member information such as race, ethnicity, and disability status into a tracking database or merging with available demographic data to monitor for issues or trends.
- For MCEs that delegate QOCC activities, developing proactive monitoring processes for delegated activities (i.e., regular reporting and trending). Additionally, the MCE could consider reviewing and updating applicable policies to clearly articulate the process for delegating/referring BH QOCCs to the delegated entity.

5. Assessment of Health Plans' Follow-Up on FY 2020–2021 Recommendations

Region 1—Rocky Mountain Health Plans

Validation of Performance Improvement Projects

RMHP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, RMHP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, RMHP reported that it implemented the following interventions:

- Quarterly and annual SHCN audit for members 0–20 years of age. Internal quality audit of members 0–20 years of age identified as having a SHCN.
- Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

- RMHP was required to update the member liability language in the provider manual to accurately address the various LOB that may have variations in copay and liabilities.

- RMHP was required to update the delegated credentialing agreements that did not include the full detailed language specified in CMS regulations.

RMHP did not have any required actions for Standard VIII—Credentialing and Recredentialing and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. RMHP submitted final CAP documents in November 2021. Following the Department's approval, RMHP completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- RMHP confirmed that the health plan verifies its data with providers regularly, including provider surveys and attestations.
- The data sources for both the quarterly network report (NAV) and online directory are the same, but both reflect a moment in time of data that is continually updated.
- The online directory is managed in a manner to present the information for a consumer audience, thus it can reflect provider preferences such as individual versus practice listings. The NAV report is managed in a manner to reflect the requirements of the template.

Encounter Data Validation—RAE 411 Over-Read

RMHP reported that its network department developed a one-page summary that was shared in the provider newsletter and trainings. During internal meetings, RMHP posted the RAE 411 results to discuss current encounter reports and whether there is a need for more ongoing proactive staff education and collaboration between benefit configuration, provider network management, claims, and the audit team.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the Patient-Centered Medical Home (PCMH) CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, RMHP reported engaging in the following QI initiatives:

- Implemented a process to notify PR, who will follow up with the provider, and the Value Based Contracting Review Committee (VBCRC) when customer service is informed by members that a healthcare provider is not accepting new patients or is requiring applications for acceptance.
- Integrated BH components in RAE value-based contracts.

- Educated members on the importance of having a primary care relationship with a PCP during welcome calls and offered to help members find a PCP if they do not have one.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, through mailers and emails; the addition of QR codes to existing mailers; and business cards for care coordinators and external stakeholders to distribute.
- Increased provider awareness of the CAHPS survey and encouraged PCPs to deliver high-quality, patient-centered care through the discussion of a CAHPS educational video series with practices and the distribution of the video on the RMHP website.
- Included member experience topics (e.g., leadership training, BH skills training, care management training, MA skills and training, telehealth visits) in newsletter articles, learning collaborative events, and webinar series.
- Provided cultural competency training to providers at care management training and BH skills training.
- Launched an eConsult initiative in Mesa County for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc., which may reduce referrals to specialists with long wait times, empower the primary care practice, and increase education/clinical pathways within primary care.
- Implemented a structure within the RAE value-based contracts where practices are held accountable to CAHPS scores to support practices in patient experience strategies that may yield positive CAHPS results and satisfaction with providers year over year.
- Offered several programs, tools, and resources to help practices implement QI initiatives that aim to improve member outcomes on several high-priority measures so they will be well received by providers and can be sustained long term through the clinical quality improvement (CQI) team in collaboration with Integrated Quality Workgroups.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, RMHP reported that the network department developed a one-page BH billing reference sheet, which was shared in the RMHP provider newsletter and trainings. RMHP staff members reported meeting to discuss encounter reports and any need for ongoing, proactive staff education and collaboration between benefit configuration, provider network management, claims, and the audit team.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, RMHP achieved 100 percent compliance. However, HSAG recommended the Department encourage RMHP to evaluate documentation protocols when evaluating if a request for service is a new or concurrent request to ensure accuracy and that the requests are processed using the correct time frame. All RMHP clinical staff members received monthly refresher trainings on aspects of authorization input to ensure appropriate selection when an authorization is created. Additionally, each month a random sample of cases were pulled for an audit conducted by supervisors for each UM staff member. If issues were identified during the audit, the UM staff member received additional 1:1 coaching.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for RMHP.

Region 2—Northeast Health Partners

Validation of Performance Improvement Projects

NHP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, NHP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, NHP reported that it implemented the following interventions:

- Tracked all performance measures including those within the Behavioral Health Incentive Program (BHIP). NHP presents performance across several different committees including the alternating bimonthly QM Committee and Quality Improvement/Population Health (QI/Pop Health) Committee, the quarterly regional Performance Improvement Advisory Committee (PIAC), and the quarterly quality meeting with the CMHCs.
- Worked to align measures and activities where possible including connecting Potentially Avoidable Complication (PAC) activities to BHIP measures and the Behavioral Health Expansion Plan, and continuing those efforts into the SFY 2023 Population Health Plan. NHP was able to conduct analyses and surface information on SUD within the region and within the pediatric population. Further, NHP surveyed regional providers to gather insight into some of the barriers facing clinicians in treating SUD in the pediatric population.
- Targeted performance improvement activities are underway across several BHIP measures including *Depression Screening for Foster Care* and the *7-Day Follow-Up After an Inpatient Mental Health Discharge*. The *7-Day Follow-Up After an Inpatient Mental Health Discharge* activities include current and future state process maps at a CMHC to identify the organization's process for scheduling and follow-up (current state), and the process integrating NHP's delegated care coordination entity (future state). Feasibility in replicating this exercise at one of the hospitals is currently being assessed.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

- NHP was required to clarify in informational materials that while an individual provider may have moral or religious objections, NHP as an organization does not. NHP was required to update informational materials to state that when providers object to services, the member should be referred back to NHP, so that, if appropriate, an alternative provider can be assigned.
- NHP was required to update policies, procedures, and processes to ensure that providers are not declined based on discriminatory reasons and implement written processes to confirm that listings in practitioner directories are consistent with credentialing data, including education, training, and certification.
- NHP was required to update the delegated credentialing agreements to include all required CMS language.

NHP did not have any required actions for Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. NHP submitted final CAP documents in January 2022. Following the Department's approval, NHP completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- HCI continued to fully participate in quarterly NAV reporting throughout FY 2021–2022, beginning with quarterly network adequacy report and network data submission to the Department in July 2021.
- HCI has updated language in the *Behavioral Health Handbook* and in the *Primary Care Handbook* to clarify that in the event that an individual provider may object to a service on moral or religious grounds, HCI as an organization does not share the objection. HCI has updated informational materials to state that should a provider object to services on moral or religious grounds, the affected member will be referred back to HCI for assignment to a different provider.

Encounter Data Validation—RAE 411 Over-Read

Prior to engaging in the annual claims and encounter audit, NHP completed a 411 audit training with its provider network. NHP reported that the training included an overview of the audit and documentation tips for providers in order to be successful in the annual audit. NHP requested that each provider utilize

the training as part of their own internal training in order to enhance documentation related to the annual audit.

After the audit was concluded, NHP reviewed the performance scores by provider and encounter service category and either offered training or assigned a corrective action to any provider that demonstrated performance that fell below 90 percent.

NHP worked with North Range Behavioral Health on a QUIP project and noted that the aim of the QUIP was to focus on low-performing encounter service categories. As a targeted intervention, NHP provided training on these categories to North Range Behavioral Health, and subsequent chart audits took place over three months to test the validity of the targeted intervention. NHP reported that it considered this a successfully completed performance project due to the overall increase in scores within the project study, and the interventions executed demonstrated successful results. NHP noted that it believes it has demonstrated solid improvement with the interventions presented in this study as well as the associated results. The interventions will be adopted and can be used for further improvement moving forward. For example, NHP reported that the training conducted on Uniform Service Coding Standards (USCM) requirements and best practice documentation for these encounter categories are transferable to the current encounter categories for the 411 audit for all facilities/providers. NHP reported that the auditing and monitoring of encounter categories has continued through the efforts set forth in the annual 411 claims and encounter audit. Lastly, NHP noted that the training and education can be incorporated into future documentation training done with BH providers in the region after the results of the 411 audit are tabulated.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, NHP reported engaging in the following QI initiatives:

- Shared CAHPS results with participating practices across a number of different avenues including the QM Committee, QI/Pop Health Committee, PIAC, and the October ACC Learning Collaborative, and those practices subsequently shared the CAHPS performance with the leadership teams within their organizations.
- Reached out to providers taking part in the survey and supplied them with the survey materials being provided to members in an effort to educate them on the CAHPS process and assist with response rates.
- Asked participating providers to relay the importance of taking the survey if contacted with members seen in office during the survey period.

- Expanded the number of BH practices offering after-hours care from 988 practices at the end of Q1 FY 2020–2021 to 1,067 practices by the end of Q4 FY 2020–2021.
- Expanded access to care through telemedicine, including leveraging the telehealth strategy of its ASO, Beacon, to research and recruit e-health entities operating in the region.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, NHP reported incorporating best practices and specific trainings developed for the QUIP as necessary to comply with billing and coding requirements for all providers. NHP discussed the prospect of incorporating the trainings into future training for documentation requirements with BH providers, as well as ongoing auditing and monitoring for all providers with low accuracy scoring encounter data types.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, HSAG found that NHP did not show evidence that a peer-to-peer review was offered to the requesting provider prior to the denial of requested services within some of the records reviewed. NHP reported the issue was identified as a training gap, and additional training was provided to all UM staff members in the first quarter of FY 2021–2022. The training included:

- Overview of the goals and purposes of the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Review of the NHP/Beacon MHPAEA policy.
- Review of standard operating procedures for processing denials to ensure compliance with MHPAEA policy and other policies relating to NABD, including the requirement to offer a peer-to-peer review prior to finalizing a denial, NABD timelines, culturally and linguistically appropriate service standards for language and readability, proper coding and documentation of reasons for denials, and use of the state-approved NABD letter template.

Additionally, UM staff members are required to take an annual online training related to MHPAEA and achieve a passing score of 80 percent or greater on a learning post-test. All UM staff members must take an annual IRR on the application of the InterQual and ASAM medical necessity criteria and achieve a passing score of 80 percent or greater. All UM staff members successfully passed each of these training requirements in FY 2021–2022. As a final check of understanding and proper application of the MHPAEA requirements, UM staff members additionally participate in regular record audits performed by peers and supervisors. Any deviation from the standard is addresses through additional training and supervision.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for NHP.

Region 3—Colorado Access

Validation of Performance Improvement Projects

COA Region 3 successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, COA Region 3 developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

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:

- In September 2020, COA Region 3 expanded the established P4P Workgroup structure to begin holding a series of monthly workgroups with Providers designed to address and improve performance on certain prioritized key performance indicators (KPIs). The KPI Provider Workgroups were developed in an effort to drive performance for the Well, Dental, Behavioral Health Engagement KPIs. Although these workgroups were developed to focus on KPI improvement, the efforts around behavioral health engagement will result in benefits that intersect with the BHIP 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 3 has identified barriers and areas of opportunity within practices and provider groups, gained significant knowledge on strengths and best practices, and strengthened provider alliances through these workgroups. These workgroups continued through the FY 2021–2022, and planning is underway to continue operations through FY 2022–2023 to allow for continued 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 has built strong partnerships with the inpatient hospitals within its network. COA Region 3 has increased its collaboration with the hospitals through ongoing meetings to review performance on the measure, perform data analysis, and provide guidance on process improvement opportunities. Hospitals have started to receive monthly data including member follow-up, outpatient referral sources, and their performance on the metric. COA Region 3 continues to utilize the ADT system for coordination with CMHCs. The 7-day follow up value-based contracts are still in place and the dashboard is utilized to facilitate collaboration with the hospitals. A provider survey was sent to hospitals engaged in the value-based payments to solicit feedback for future incentive projects.
- For the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure, COA Region 3 has monthly meetings with all five Denver Human Services (DHS) counties to collaborate on this metric. COA Region 3 is working on an internal dashboard to track members entering foster care and subsequent claims. COA Region 3 has partnered with primary care physicians, child placement agencies, and DHS counties to identify areas in which a foster care intervention can be implemented to ensure timely assessment. Adams County and Douglas County have started a data-sharing intervention to garner access to the data more quickly. COA Region 3 plans to use these data and the dashboard to expand the interventions.
- For the *Follow-Up After a Positive Depression Screen* measure, COA Region 3 has included the depression screen and follow up measure in all value-based payment programs for PCMPs. Performance on this measure impacts administrative payments. Biannual audits now include review of follow-up plans in the EHR and practice facilitators are working one-on-one with practices to improve screening workflows, billing procedures, and connection to resources.
- For the *Engagement in Outpatient SUD Treatment* measure, COA Region 3 established a value-based model to incentivize engagement following a 3.2 withdrawal management (WM) episode of care. EDs and other types of providers are educated in referral processes and available outpatient services. Outpatient medication-assisted treatment (MAT) services contribute to this measure, but COA Region 3 has expanded the role of outpatient engagement through incentives for high-performing 3.2 WM providers who ensure more outpatient connections occur.
- For the *Follow-Up Within 7 Days of an ED Visit for SUD* measure, work has been initiated with EDs and 3.2 WM (as many times members go from ED to 3.2 WM) to educate and incentivize engagement. For its 3.2 withdrawal management value-based (WM VB) contracts, COA Region 3 has defined engagement as three treatment appointments within 30 days of discharge from WM. The 3.2 WM providers have been highly successful in earning incentives based on their engagement performance over the last year. This value-based model continues and is reviewed in quarterly time frames.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), COA Region 3 did not have any findings resulting in required actions.

Validation of Network Adequacy

- COA Region 3 seeks opportunities to expand the care network to ensure adequate network providers and access to care. Building on the foundation of the existing Region 3 network, COA Region 3 continued to use various resources to further target potential additions and grow the network of providers. COA Region 3 has a dedicated provider contracting team that responds to inquiries and requests to participate in the network.
- COA Region 3 is dedicated to contracting with every willing state-validated provider to become part of the Region 3 network, regardless of their location, provided they meet the credentialing and contracting criteria.

Encounter Data Validation—RAE 411 Over-Read

COA Region 3 reported that it implements CAPs for providers that score below 95 percent in the RAE 411 audit and has a sufficient number of records to assess general documentation practices. COA Region 3 noted that CAPs may include requirements such as root cause analyses, retraining staff members, systems enhancements, and/or provider re-audits. COA Region 3 reported that it also offers provider education and training on quality documentation in collaboration with its quality department, practice support team and provider network managers. COA Region 3 also continues to maintain a claims audit program that utilizes an annual audit plan. COA Region 3 noted that the annual plan is based on risk assessments, of which the RAE 411 audit performance is an element.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, COA Region 3 reported engaging in the following QI initiatives:

- Identified opportunities to improve member experience through the collection and analyzation of data received from a third iteration of a qualitative member satisfaction survey that was

administered through the quality department, which encouraged members to share what is important to them in terms of health services, how care could be improved, and where they typically receive health information. These opportunities included improving COA Region 3's member-facing side of the website, provider directory, network maintenance processes, and the new member enrollment booklet.

- Continued the Customer Service Quality Monitoring program, including continuous monitoring of Net Provider Scores (NPS), which also resulted in increased interdepartmental collaboration on QI projects, an improved understanding of member experience, and increased engagement from customer service representatives who participate in member-facing work daily.
- The quality department utilized the Colorado Access Member Advisory Council to gather feedback on survey questions, engage members, address gaps in the survey, and provide members with data around member experience before implementing the fourth iteration of the member survey in collaboration with the customer service department.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, COA Region 3 described engaging in a "claims audit program" using an annual audit plan based on risk assessments of specific providers with low-scoring encounter data types. COA Region 3 discussed continued follow-up with staff members and providers to ensure ongoing accuracy, utilizing CAPs to ensure providers meet the general documentation standards, and ongoing provider education in collaboration with the quality department, practice support team, and provider network managers.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, COA achieved 100 percent compliance and did not have any formal recommendations on which to follow up.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for COA Region 3.

Region 4—Health Colorado, Inc.

Validation of Performance Improvement Projects

HCI successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, HCI developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, HCI reported that it implemented the following interventions:

- HCI's Quality Improvement Utilization Management (QIUM) Committee completed regular monthly reviews of the FY 2020–2021 KPIs, Behavioral Health Performance Incentive Measures, and Performance Pool results. These measures were calculated based off the Colorado Department of Health Care Policy and Financing (HCPF) methodology presented in the specification documents when received from HCPF.
- HCI created a Performance Measures Improvement Strategy that included the following:
  - Performance Measure Strategy #1—Excellent Bi-Directional HCPF Communication Around Performance Measures (HCI Performance Measures Strategy Workgroup)
    - Element #1—Ensure measure changes communicated to all pertinent parties
    - Element #2—Provide comprehensive feedback to HCPF on all measures (e.g., coding gaps)
  - Performance Measure Strategy #2—Improve Timeliness and Accuracy of Internal Performance Measures Data (HCI Performance Measures Data Workgroup)
    - Element #1—Aggregate level visualization (dashboards) data for each measure (slice by RAE level, care coordination level, provider level—group and practice), attention to equity in data slicing
    - Element #2—Provider/practice-level patient detail per measure

  - Performance Measure Strategy #3—Win on All Performance Measures (HCI Performance Measures Strategy Workgroup)
    - Element #1—Measure improvement prioritization
      - Prioritization Matrix—Strategy workgroup determines criteria (possible examples: how far from target, how many stakeholders required to improve measure, resources available, interrelated measures, finances)
    - Element #2—Effectively engage key stakeholders for improvement
      - Evaluate top performers (Gather Best Practice) and bottom performers (Facilitated Improvement) for each measure
    - Element #3—Process improvement facilitation (Dedicated Process Improvement Staff and Governance Structure)
      - Network/Practice Transformation (primary care and BH)—Convene, motivate, and facilitate practices to improve practice-level metrics and share best practice
      - RAE/Neighborhood Transformation (Performance Measures Action Plan [PMAP])—Convene, motivate, and facilitate key stakeholders to improve RAE level measures
      - Care Coordination Transformation (Value Stream)—Convene, motivate, and facilitate key stakeholders to improve RAE-level measures
    - Element #4—Effectively Incentivize Network to Perform on Key Measures
      - Clearly articulated funds flow to provider/key stakeholder for performance
      - Facilitate engagement by providing meaningful/actionable data, improvement tools, and coaching

- In FY 2020–2021, HCI's Performance Measures Strategy Workgroup began pre-planning for implementation of the PMAP Workgroup. The purpose of PMAP is to serve as a mechanism to further the HCI Performance Measures Strategy Workgroup's planning efforts and to drive performance improvement in collaboration with key Region 4 stakeholders. Serving as a collaborative to promote learning and improvement, the HCI Performance Measures Strategy Workgroup will meet monthly at a minimum and report PMAP findings to the HCI QIUM Committee monthly. Key stakeholders involved in the PMAP effort are Region 4 partners/providers, QM staff, HCI leadership, and members of the HCI QIUM Committee. The workgroup will be led by a member of the HCI QIUM Committee and/or QM staff. Over the course of FY 2020–2021, HCI leadership and members of the HCI Performance Measures Strategy Workgroup focused on establishing a strategic framework to address performance measurement activity for Region 4 on the following contract-based measures:
  - KPIs
  - BHIP
  - Performance Pool

  Reviewing performance in relation to benchmarks/goals/targets, the workgroups will periodically rank order measures, determining which measures to focus the performance improvement activity on within a rapid cycle framework. The PMAP Workgroup will be comprised of key Region 4

partners/providers identified as strong performers to identify and document best practices as well as work with partners/providers with opportunities for improvement who are willing to implement best practices. The workgroups will report their activities in the monthly HCI QIUM Committee meetings, including review of RAE and provider-level performance data, and identify potential countermeasures to increase overall performance. The PMAP template will serve as a road map to document and guide the workgroups' efforts along with the use of additional performance improvement tools (e.g., key driver diagram, FMEA). The PMAP Workgroup began to focus on prioritized measures in early FY 2021–2022 and will increase its efforts for FY 2022–2023. Region 4 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 HCI QIUM Committee and the HCI Performance Measures Strategy Workgroup. Once a meaningful, manageable, and measurable set of interventions are identified and approved by the HCI Performance Measures Strategy Workgroup, the workgroups will coordinate with partners/providers to implement the interventions and/or countermeasures and monitor performance over time, sharing ongoing findings with the HCI QIUM Committee and HCI's Board of Directors. The workgroups will follow a rapid cycle, iterative process of planning, taking action (including any countermeasures), studying, and monitoring performance, and acting on what is learned with partners/providers.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

- HCI was required to clarify in informational materials that while an individual provider may have moral or religious objections, HCI as an organization does not. HCI was required to update informational materials to state that when providers object to services, the member should be referred back to HCI, so that, if appropriate, an alternative provider can be assigned.
- HCI was required to update policies, procedures, and processes to ensure that providers are not declined based on discriminatory reasons and implement written processes to confirm that listings in practitioner directories are consistent with credentialing data, including education, training, and certification.
- HCI was required to update the delegated credentialing agreements to include all required CMS language.

HCI did not have any required actions for Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. HCI submitted the final CAP documents in January 2022. Following the Department's approval, HCI completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- NHP continued to fully participate in quarterly NAV reporting throughout FY 2021–2022, beginning with the quarterly network adequacy report and network data submission to the Department in July 2021.
- NHP has updated language in the *Behavioral Health Handbook* and in the *Primary Care Handbook* to clarify that in the event that an individual provider may object to a service on moral or religious grounds, NHP as an organization does not share the objection. NHP has updated informational materials to state that should a provider object to services on moral or religious grounds, the affected member will be referred back to NHP for assignment to a different provider.

Encounter Data Validation—RAE 411 Over-Read

Prior to engaging in the annual claims and encounter audit, HCI completed a 411 audit training with its provider network. HCI reported that the training included an overview of the audit and documentation tips for providers in order to be successful in the annual audit. HCI requested that each provider utilize the training as part of their own internal training in order to enhance documentation related to the annual audit.

After the audit was concluded, HCI reviewed the performance scores by provider and encounter service category and either offered training or assigned a corrective action to any provider that demonstrated performance that fell below 90 percent.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, HCI reported engaging in the following QI initiatives:

- Contacted and supplied survey information to practices who were surveyed regarding potential member contact.
- Evaluated and formatted survey results for presentation and review once they were received and will identify interventions that can increase performance.
- Will work with Valley-Wide Health Systems to increase the satisfaction response to child access questions on the CAHPS survey.

- Reached out to providers taking part in the survey and supplied them with the survey materials being provided to members in an effort to educate them on the CAHPS process and assist with response rates.
- Asked participating providers to relay the importance of taking the survey if contacted with members seen in office during the survey period.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, HCI reported continuing interventions, where applicable, and offering providers with ongoing performance below the 90 percent threshold the option of receiving training or being placed on a CAP. HCI discussed that the most effective intervention was to conduct training on proper coding of services at the provider level; therefore, HCI plans to continue implementing training to impact accuracy rates.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, HSAG found that HCI did not show evidence that a peer-to-peer review was offered to the requesting provider prior to the denial of requested services within some of the records reviewed. HCI reported the issue was identified as a training gap, and additional training was provided to all UM staff members in the first quarter of FY 2021–2022. The training included:

- Overview of the goals and purposes of MHPAEA.
- Review of the HCI/Beacon MHPAEA policy.
- Review of standard operating procedures for processing denials to ensure compliance with MHPAEA policy and other policies relating to NABD, including the requirement to offer a peer-to-peer review prior to finalizing a denial, NABD timelines, culturally and linguistically appropriate service standards for language and readability, proper coding and documentation of reasons for denials, and use of the state-approved NABD letter template.

Additionally, UM staff members are required to take an annual online training related to MHPAEA and achieve a passing score of 80 percent or greater on a learning post-test. All UM staff members must take an annual IRR on the application of the InterQual and ASAM medical necessity criteria and achieve a passing score of 80 percent or greater. All UM staff members successfully passed each of these training requirements in FY 2021–2022. As a final check of understanding and proper application of the MHPAEA requirements, UM staff members additionally participate in regular record audits performed by peers and supervisors. Any deviation from the standard is addresses through additional training and supervision.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for HCI.

Region 5—Colorado Access

Validation of Performance Improvement Projects

COA Region 5 successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, COA Region 5 developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

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:

- 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 performance on certain prioritized KPIs. The KPI Provider Workgroups were developed in an effort to drive performance for the Well, Dental, Behavioral Health Engagement KPIs. Although these workgroups were developed to focus on KPI improvement, the efforts around behavioral health engagement will result in benefits that intersect with the BHIP 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 within practices and provider groups, gained significant knowledge on strengths and best practices, and strengthened provider alliances through these workgroups. These workgroups continued through the FY 2021–2022, and planning is underway to continue operations through FY 2022–2023 to allow for continued 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 has built strong partnerships with the inpatient hospitals within its network. COA Region 5 has increased its collaboration with the hospitals through ongoing meetings to review performance on the measure, perform data analysis, and provide guidance on process improvement opportunities. Hospitals have started to receive monthly data including member follow-up, outpatient referral sources, and their performance on the metric. COA Region 5 continues to utilize the ADT system for coordination with CMHCs. The 7-day follow up value-based contracts are still in place and the dashboard is utilized to facilitate collaboration with the hospitals. A provider survey was sent to hospitals engaged in the value-based payments to solicit feedback for future incentive projects.
- For the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure, COA Region 5 partners with DHS and Eastside Clinic to ensure timely screening of foster youth. COA Region 5 has a practice supports facilitator assigned to this practice. This facilitator reviews performance metrics, provides process improvement guidance, and is available to troubleshoot issues as they arise. COA Region 5 plans to use the dashboard in partnership with Eastside Clinic and DHS to identify gaps, analyze data, and provide intervention.
- For the *Follow-Up After a Positive Depression Screen* measure, COA Region 5 has included the depression screen and follow up measure in all value-based payment programs for PCMPs. Performance on this measure impacts administrative payments. Biannual audits now include review of follow-up plans in the EHR and practice facilitators are working one-on-one with practices to improve screening workflows, billing procedures, and connection to resources.
- For the *Engagement in Outpatient SUD Treatment* measure, COA Region 5 established a value-based model to incentivize engagement following a 3.2 WM episode of care. EDs and other types of providers are educated in referral processes and available outpatient services. Outpatient MAT services contribute to this measure, but COA Region 5 has expanded the role of outpatient engagement through incentives for high-performing 3.2 WM providers who ensure more outpatient connections occur.
- For the *Follow-Up Within 7 Days of an ED Visit for SUD* measure, work has been initiated with EDs and 3.2 WM (as many times members go from ED to 3.2 WM) to educate and incentivize engagement. For its 3.2 WM VB contracts, COA Region 5 has defined engagement as three treatment appointments within 30 days of discharge from WM. The 3.2 WM providers have been highly successful in earning incentives based on their engagement performance over the last year. This value-based model continues and is reviewed in quarterly time frames.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), COA Region 5 did not have any findings resulting in required actions.

Validation of Network Adequacy

COA Region 5 did not provide information about follow-up on FY 2020–2021 recommendations in Region 5.

Encounter Data Validation—RAE 411 Over-Read

COA Region 5 reported that it implements CAPs for providers that score below 95 percent in the RAE 411 audit and has a sufficient number of records to assess general documentation practices. COA Region 5 noted that CAPs may include requirements such as root cause analyses, retraining staff members, systems enhancements, and/or provider re-audits. COA Region 5 reported that it also offers provider education and training on quality documentation in collaboration with its quality department, practice support team and provider network managers. COA Region 5 also continues to maintain a claims audit program that utilizes an annual audit plan. COA Region 5 noted that the annual plan is based on risk assessments, of which the RAE 411 audit performance is an element.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, COA Region 5 reported engaging in the following QI initiatives:

- Identified opportunities to improve member experience through the collection and analyzation of data received from a third iteration of a qualitative member satisfaction survey that was administered through the quality department, which encouraged members to share what is important to them in terms of health services, how care could be improved, and where they typically receive health information. These opportunities included improving COA Region 5's member-facing side of the website, provider directory, network maintenance processes, and the new member enrollment booklet.
- Continued the Customer Service Quality Monitoring program, including continuous monitoring of NPS, which also resulted in increased interdepartmental collaboration on QI projects, an improved understanding of member experience, and increased engagement from customer service representatives who participate in member-facing work daily.
- The quality department utilized the Colorado Access Member Advisory Council to gather feedback on survey questions, engage members, address gaps in the survey, and provide members with data around member experience before implementing the fourth iteration of the member survey in collaboration with the customer service department.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, COA Region 5 described engaging in a "claims audit program" using an annual audit plan based on risk assessments of specific providers with low-scoring encounter data types. COA Region 5 discussed continued follow-up with staff members and providers to ensure ongoing accuracy, utilizing CAPs to ensure providers meet the general documentation standards, and ongoing provider education in collaboration with the quality department, practice support team, and provider network managers.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, HSAG found conflicting information about the denial within some of the NABDs reviewed. COA Region 5 reported an update to a policy to clarify the different definitions of "medical necessity" to ensure the definitions are aligned with statutory and contractual requirements. Additionally, COA Region 5 created a new section of the policy to outline which criteria should be used for each type of service that is subject to UM review.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for COA Region 5.

Region 6—Colorado Community Health Alliance

Validation of Performance Improvement Projects

CCHA Region 6 successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, CCHA Region 6 developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

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:

- Created improvement strategies for all five BHIP measures, and it works across RAEs to identify and exchange information on best practices and brainstorm solutions to improve performance.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), CCHA Region 6 did not have any findings resulting in required actions.

Validation of Network Adequacy

- CCHA Region 6 confirmed that the information in the provider directory is aligned with the network data submitted to the Department in that the same system is used to store and manage the provider information.
- CCHA Region 6 verified the accuracy of this information using monthly audits to review a sample of records, and through quarterly reporting QA processes. CCHA Region 6 maintains accurate

provider information using the annual office systems reviews process, and communicates to providers the requirement to maintain updated information via the provider newsletter and provider manuals.

- Although the PH and BH network directory data source is the same, some variances are expected due to how the data are publicly displayed versus internally maintained. CCHA Region 6 launched a new functionality on the provider directory where a member can report inaccurate information for a provider directly from the provider search page.

Encounter Data Validation—RAE 411 Over-Read

Based on HSAG's recommendation for CCHA Region 6 to continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed, CCHA Region 6 implemented several interventions to promote ongoing improvements on the accuracy of encounter data submissions. In addition to the News and Updates newsletter CCHA Region 6 sends to providers monthly, it also offers a BH provider bulletin to augment its communication strategy with specific content relevant to BH providers, including changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for their practice representatives.

CCHA Region 6 reported that it initiated additional checks and troubleshooted encounter data submissions in order to provide accurate data for audit sampling. CCHA Region 6 noted that it developed and disseminated guidelines throughout the year as well as with the request for records to provide additional clarity on audit requirements and common mistakes, and also distributed a self-audit checklist to facilitate providers' review of their documentation in accordance with standards. Upon completion of the EDV phase of the audit, CCHA Region 6 furnished practice-level scorecards with the providers' results on each audited element to ensure participants were informed of their performance and to guide necessary corrections.

CCHA Region 6 noted that claims information is regularly reviewed to identify practices that may benefit from additional assistance. CCHA Region 6 also reported that its care consultants have begun working with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements and reduce the number of denied claims. CCHA Region 6 also utilizes CAPs as needed to provide the structure, clarity of expectations, and accountability for established improvement efforts.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, CCHA Region 6 reported engaging in the following QI initiatives:

- Practice transformation coaches (PTCs) shared data with practices whose members were surveyed and worked with their QI teams to identify and implement the following interventions:
  - PTCs tracked the third next available appointments every quarter to measure how many days it takes for members to get appointments for needed care to improve access to care. Practices who scored outside of contract standards reviewed workflows, cycle times, and wait times to appointments.
  - PTCs encouraged practices to implement Patient and Family Advisory Councils (PFACs) aligned with alternative payment model (APM) initiatives to improve patient-centered communication through the review of materials and feedback gained communicating 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 to improve the coordination of medical care.
- PTCs will continue to share data with practices surveyed and work with their QI teams to build on interventions around categories with the lowest scores that were started in the last fiscal year, beginning with access to care, patient-centered communication, and coordination of medical care for adults and pediatrics, as applicable.
- PTCs will identify any successful interventions and/or best practices and share them across all PCMPs, as appropriate.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, CCHA Region 6 reported implementing various approaches to ensure billing requirements are followed appropriately, such as: utilizing the monthly News and Updates newsletter and a BH provider bulletin to communicate with providers about updates to billing and coding practices, educational information, and available trainings and resources. CCHA Region 6 discussed regular audits and associated feedback as well as placing providers on CAPs to address any ongoing documentation issues.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, HSAG found that CCHA Region 6 was not in compliance for timeliness in regard to sending the member an NABD, despite having appropriate policies and procedures to ensure the NABD is sent within a timely manner. Additionally, multiple NABDs contained complex or confusing language for the member. CCHA Region 6 implemented several processes in SFY 2021–2022 to ensure compliance of contractual timelines when sending an NABD following an adverse decision. The processes included increasing the mandatory annual training to semiannual trainings for UM management staff members, updating desktop procedures for UM

management staff members, and conducting live audits to include NABD letter compliance. Furthermore, CCHA Region 6 implemented changes to update the NABD letter template to ensure that the NABDs were easy to read and understand for the member. The changes to the NABD letter template included:

- Removing the reference to the *Health First Colorado Member Handbook* as a reason a service would not be covered.
- Changing the administrative denials to include detailed rationale based on the denial.
- Decreasing the use of medical language/jargon and updating language to include the description.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for CCHA Region 6.

Region 7—Colorado Community Health Alliance

Validation of Performance Improvement Projects

CCHA Region 7 successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, CCHA Region 7 developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

To improve its BH incentive measure rates from the previous fiscal year, CCHA Region 7 reported that it implemented the following interventions:

- Created improvement strategies for all five BHIP measures, and it works across RAEs to identify and exchange information on best practices and brainstorm solutions to improve performance.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), CCHA Region 7 did not have any findings resulting in required actions.

Validation of Network Adequacy

- CCHA Region 7 confirmed that the information in the provider directory is aligned with the network data submitted to the Department in that the same system is used to store and manage the provider information.
- CCHA Region 7 verified the accuracy of this information using monthly audits to review a sample of records, and through quarterly reporting QA processes. CCHA Region 7 maintains accurate

provider information using the annual office systems reviews process, and communicates to providers the requirement to maintain updated information via the provider newsletter and provider manuals.

- Although the PH and BH network directory data source is the same, some variances are expected due to how the data are publicly displayed versus internally maintained. CCHA Region 7 launched a new functionality on the provider directory where a member can report inaccurate information for a provider directly from the provider search page.

Encounter Data Validation—RAE 411 Over-Read

Based on HSAG's recommendation for CCHA Region 7 to continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed, CCHA Region 7 implemented several interventions to promote ongoing improvements on the accuracy of encounter data submissions. In addition to the News and Updates newsletter CCHA Region 7 sends to providers monthly, it also offers a BH provider bulletin to augment its communication strategy with specific content relevant to BH providers, including changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for their practice representatives.

CCHA Region 7 reported that it initiated additional checks and troubleshooted encounter data submissions in order to provide accurate data for audit sampling. CCHA Region 7 noted that it developed and disseminated guidelines throughout the year as well as with the request for records to provide additional clarity on audit requirements and common mistakes, and also distributed a self-audit checklist to facilitate providers' review of their documentation in accordance with standards. Upon completion of the EDV phase of the audit, CCHA Region 7 furnished practice-level scorecards with the providers' results on each audited element to ensure participants were informed of their performance and to guide necessary corrections.

CCHA Region 7 noted that claims information is regularly reviewed to identify practices that may benefit from additional assistance. CCHA Region 7 also reported that its care consultants have begun working with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements and reduce the number of denied claims. CCHA Region 7 also utilizes CAPs as needed to provide the structure, clarity of expectations, and accountability for established improvement efforts.

PCMH CAHPS

Although in FY 2021–2022 (the reporting year for this annual technical report) HSAG administered the CAHPS 5.1H health plan survey for the Colorado RAE population, in the prior year (FY 2020–2021), HSAG administered the PCMH CAHPS survey. Following are the RAE's activities reported as follow-up to the PCMH CAHPS results for FY 2020–2021.

To improve member perceptions related to FY 2020–2021 PCMH CAHPS results, CCHA Region 7 reported engaging in the following QI initiatives:

- PTCs shared data with practices whose members were surveyed and worked with their QI teams to identify and implement the following interventions:
  - PTCs tracked the third next available appointments every quarter to measure how many days it takes for members to get appointments for needed care to improve access to care. Practices who scored outside of contract standards reviewed workflows, cycle times, and wait times to appointments.
  - PTCs encouraged practices to implement PFACs aligned with APM initiatives to improve patient-centered communication through the review of materials and feedback gained communicating 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 to improve the coordination of medical care.
- PTCs will continue to share data with practices surveyed and work with their QI teams to build on interventions around categories with the lowest scores that were started in the last fiscal year, beginning with access to care, patient-centered communication, and coordination of medical care for adults and pediatrics, as applicable.
- PTCs will identify any successful interventions and/or best practices and share them across all PCMPs, as appropriate.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, CCHA Region 7 reported implementing various approaches to ensure billing requirements are followed appropriately, such as: utilizing the monthly News and Updates newsletter and a BH provider bulletin to communicate with providers about updates to billing and coding practices, educational information, and available trainings and resources. CCHA Region 7 discussed regular audits and associated feedback as well as placing providers on CAPs to address any ongoing documentation issues.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, HSAG found that while CCHA Region 7's policies and procedures described proactively offering peer-to-peer review with the requesting provider prior to finalizing a denial determination, CCHA Region 7 did not adequately document the offer for every denial within the electronic documentation system. CCHA Region 7 was not in compliance in regard to sending the member an NABD within the required time frame. Additionally, most NABDs also contained complex and confusing information for the member.

CCHA Region 7 implemented several processes in SFY 2021–2022 to address the findings by HSAG, including:

- Increasing the mandatory annual training to semiannual trainings for UM management staff members.
- Updating desktop procedures for UM management staff members.
- Conducting live audits to include peer-to-peer review and NABD letter compliance.
- Removing the reference to the *Health First Colorado Member Handbook* within the NABD as a reason a service would not be covered.
- Changing the administrative denials to include detailed rationale based on the denial.
- Decreasing the use of medical language/jargon and updating language to include the description in the NABD.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for CCHA Region 7.

Denver Health Medical Plan

Validation of Performance Improvement Projects

DHMP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, DHMP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

HEDIS Measure Rates and Validation

To improve its 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 in chronic disease management, prevention, screening, annual visits. Workgroups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated BH, transitions of care, immunizations, and ambulatory care Quality Improvement Committee (QIC).
- Partnered in collaborative work process with the QI director of ACS and ACS QI staff 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 QM 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.
- For measures related to well-child visits, EPSDT, and immunizations, DHMP implemented the following:

  - Ongoing efforts continue for wraparound services outside of the MCO, and for tracking of referrals for services outside the MCO, 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 also includes how to schedule a well-child appointment. For FY 2021–2022, DHMP mailed an average of 1,670 birthday cards a month to Medicaid Choice members and an average of 122 birthday cards a month to CHP+ members.
  - EPSDT outreach conducted by the MCO will continue throughout SFY 2022–2023 and remain a powerful way to identify members in need of screenings and services.
  - School-Based Health Centers (SBHCs): Denver Health Medicaid Choice and CHP+ 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, sports physicals, immunizations, chronic disease management, primary care services, and BH care services. Denver Health and Hospital Authority (DHHA) and DHMP continue to encourage eligible members to access care through their 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. As students return to in-person learning in the 2022–2023 school year, DHMP will be restarting its collaboration with the SBHC team leads to get members who are consented to be seen at an SBHC the care they need in a timely manner. These students can now directly schedule an appointment at their SBHC through their MyChart account.

- For measures related to cancer screenings:
  - Breast cancer screening (BCS): To improve the rate of BCS, 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 6,475 female Medicaid members between July 1, 2021, and June 30, 2022.
- For measures related to asthma:
  - The Asthma Work Group (AWG) and 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 to streamline this process. In 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 2022–2023.

- For measures related to access to care:
  - DHMP continues to operate 18 SBHC) that provide healthcare in an easy and convenient setting to all 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, DHMP main campus, and the Westside Family Health Center on Federal Boulevard.
  - The new DHHA Outpatient Medical Center (OMC), a 293,000 square-foot, state-of-the-art facility located just across from the main hospital, has consolidated 20 specialty clinics, procedural areas, day surgeries, and ancillary services into one convenient location.
  - The Center for Addictions Medicine (CAM) continues to grow the addiction medicine services it offers the DHMP community. The CAM offers a full continuum of care that provides DHMP patients 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; as well as post-treatment services, tools, and resources that support ongoing recovery.
  - DHMP Medicaid Choice and CHP+ provided 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, and ancillary and hospital services. The DHMP 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 its members about their benefits and provide information on how the plan works. DHMP staff members strive for excellence in care and service for all 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, helping the member understand 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.

- DHMP continues to contract 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 at home, hospital at home, and bridging services to assist in early discharges.
- Throughout the COVID-19 pandemic, 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 members' experience. The capabilities include, but are not limited to, scheduling appointments, requesting pharmacy refills, reviewing lab results, communicating directly with providers, and providing a centralized location for tracking health outcomes and programs. It was used this year to send mass messages about the availability of COVID-19 vaccines, providing increased space and access in specialty care areas such as cardiology, orthopedics, outpatient BH, and dental services. The OMC frees space on the main campus to continue growth in pediatric services and allow 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.
- Telehealth visits continue to offer expanded access for members.
- DHMP continues to contract with STRIDE Community Health Center. The partnership adds 15 additional clinic locations (three of which have pharmacies on-site) and options for both DHMP Medicaid and CHP+ members.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

- DHMP was required to revise subcontracts to include all required CMS language.
- DHMP was required to develop mechanisms to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.

DHMP did not have any required actions for Standard VII—Provider Selection and Program Integrity or Standard VIII—Credentialing and Recredentialing. DHMP submitted final CAP documents in October 2021. Following Department approval, DHMP successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- DHMP described that it had developed and implemented a provider portal. The portal allows providers direct and immediate access to their information, including but not limited to benefits, member eligibility, accumulators, claims inquiry (submission, replace, void), referral/authorization inquiry (submission, review), and secure messaging.
- DHMP engaged Department staff members in conversations around challenges with members that reside outside of the DHMP service area. DHMP subcontracts the BH capitated program to COA, including the requirement to build and maintain a sufficient network.

Encounter Data Validation—DHMP 411 Audit Over-Read

FY 2021–2022 was the first year HSAG conducted the RAE 411 Over-Read activity with DHMP; therefore, this section is NA for DHMP.

Encounter Data Validation—MCO 412 Audit Over-Read

Denver Health Medical Center (DHMC) noted that it was selected as the pilot partner for the 412 QUIP activities and review. In collaboration with Enterprise Compliance Services (ECS), DHMP reviewed the processes that DHMC utilizes for creating and submitting claims in the three applicable service types (e.g., professional, FQHC, and outpatient) to identify potential steps in the process that can result in errors.

DHMP noted that its team has attended the DHMP/DHHA Joint Operations Committee to discuss the coding errors and to identify the primary point of contact within the DHHA coding team for outreach and collaboration. DHMP also noted that it reviews and ensures billing manuals are current.

DHMP reported that it experienced challenges in meeting the 90 percent threshold for the professional claim type due to a lack of receiving the selected medical record. DHMP noted that it denied and reprocessed all claims where medical records were not obtained for review. DHMP also reported that two provider groups were identified for not providing medical records timely. In addition to reprocessing and denying the claims, NHP noted that a PR team member was assigned to each of the groups for outreach and communication regarding the 412 processes.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, DHMP reported engaging in the following QI initiatives:

- Continued to improve communication with clinics about health plan QI initiatives, including education about health plan CAHPS 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 and care management to facilitate care transitions when acuity of need was identified.
- Increased the types of appointments (e.g., vaccines, SBHCs) that can be scheduled using MyChart.
- To address *Getting Needed Care* and *Getting Care Quickly*, DHHA:
  - Worked to provide greater appointment availability by expanding capacity, hours of operation, and specialty services.
  - Worked to expand access to care across numerous clinics and specialties including telemedicine.
  - Improved communication options by allowing established patients to message their PCP and care team and schedule primary care visits through Epic MyChart.
  - Escalated care by triaging calls when medically necessary through the DHHA appointment center.
  - Continued to have a 24-hour Nurse Line for members when the appointment center is closed and when members describe experiencing specific symptoms.
- Focused on improving consistent access to care through a delivery network that builds relationships that result in increased satisfaction with the healthcare system and better health outcomes for the population.
- Implemented a provider open shopper process by utilizing an external vendor to contact providers to request appointment availability for different types of services in an effort to monitor the networks' ability to have timely access to services.
- To address *Customer Service*, the Health Plan Customer Service (HPCS) team:
  - Provided real-time training for staff members regarding member service call QI.
  - Reviewed calls from every staff member and performed on-the-spot evaluation and training.
  - Discussed HPS phone audit report results bimonthly at the DHMP Quality Management Committee (QMC).
- Worked with the member services department to develop a work plan that will assist in identifying process improvement and staff training opportunities after tracking reasons that members cite for not getting the help or information they needed.
- Worked collaboratively with ACS clinics, providers, and committees to improve the referral process, including:
  - Working directly with the PR team to clearly communicate the different requirements for referral timeliness within the provider network.
  - Performing a quality review of the cases regularly to determine if there are any QOCCs related to potential delays in care.

  - Participating in collaborative meetings with DHHA such as the Medical Neighborhood Committee and Care Coordination Collaborative to facilitate, collaborate, and problem solve referral issues.

- Performed a health needs assessment of all new members to understand the full spectrum of members' concerns and needs related to physical and BH, as well as SDOH, and communicated the results to the care coordination team, who followed up with the member through a direct phone call to provide general information and resources including community-based organizations, referrals, connection to a medical home, and general support.
- Continued to utilize a risk stratification tool to monitor and analyze the membership's health and needs to allow a targeted outreach to members that provides the education and resources related to specific conditions or issues (e.g., high number of ED visits).

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, DHMP reported ongoing outreach and communication with providers regarding coding and documentation requirements and the continued use of the provider billing guide and newsletters, both of which are accessible on the company website. DHMP reported assigning a PR staff member as a resource to support providers with document submissions.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, DHMP achieved 100 percent compliance and did not have any formal recommendations on which to follow up.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for DHMP.

Rocky Mountain Health Plans Medicaid Prime

Validation of Performance Improvement Projects

RMHP Prime successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, RMHP Prime developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

HEDIS Measure Rates and Validation

To improve its rates from the previous fiscal year, RMHP Prime reported that it implemented the following interventions:

- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, mailing activities included:
  - Annual Wellness (CHP+ and Prime): Incentive and educational mailing brochures sent to members 3–17 years of age and included 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 interactive voice response (IVR) and postcard mailing for RAE, CHP+, and Prime members who are due for their one-year-old well visit.
  - Pediatrics Integrated Quality Workgroup (IQWg) focuses 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.
  - Well-child visits (WCV) for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - July 2021 Music on Hold (MOH) topic was WCV for kids that played during the month of July 2021 on member customer service lines for all LOB.

  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.
  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having a SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
  - Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.

- For the *Prenatal and Postpartum Care* measure, mailing activities included:
  - Postpartum Care (CHP+ and Prime): Incentive and educational mailing brochure sent to pregnant members between 37–38 weeks gestation or early delivery to encourage them to complete a postpartum visit between 1–12 weeks after delivery. Includes information on what a postpartum visit is, when the visit should be completed, and why it is important.
- For the *Prenatal and Postpartum Care* measure, other activities included:
  - Maternity and Women's Care IQWg focuses on interventions for women's health. *Prenatal and Postpartum Care* is one of the focused measures in this group.
  - RMHP care management has an outreach program for high-risk pregnant members. The member is offered case management and assistance with finding resources.
  - RMHP has partnered with WellHop, offered exclusively to RMHP CHP+, RAE, and Prime members. Through this program, expectant moms can receive additional support during their pregnancy and postpartum along with other moms with similar delivery dates to share concerns, excitements, challenges, and wins.
  - RMHP has partnered with SimpliFed to provide unlimited support through telemedicine for RMHP CHP+, RAE, and Prime members. SimpliFed is an organization that provides access to certified lactation specialists for new moms needing support with breastfeeding, pumping, formula feeding, or a combination.
  - Prenatal and postpartum care was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of May 2022.
  - Prenatal and postpartum educational message was posted to the member and provider portal during the month of May 2022.
  - Prenatal and postpartum care MOH message played during the months of April through June 2022 on member customer service lines for all LOB.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
- For the *Chlamydia Screening in Women* measure, activities included:
  - 18–21 Healthy Young Adult (Prime): Educational brochure mailed to men and women ages 18–21 years of age and includes preventive health recommendations for annual chlamydia screening in sexually active women.

  - Maternity and Women's Care IQWg focuses on interventions for women's health. *Chlamydia Screening in Women* is one of the focused measures in this group.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
  - Chlamydia screening educational message was posted to member and provider portal during the month of April 2022.
  - Website Provider tools—RMHP Clinical Practice Guidelines are posted for reference.
  - Website provider and member tools—Women's Health Screening educational landing page on the RMHP website.

- For the *Breast Cancer Screening* measure, mailing activities included:
  - Wellness that Rewards—Breast Cancer Screening (Prime): Incentive mailing brochure sent to female members 50–74 years of age through which the member is eligible to receive a gift card upon completion of breast cancer screening.

- For the *Breast Cancer Screening* measure, other activities included:
  - Maternity and Women's Care IQWg focuses on interventions for women's health. *Breast Cancer Screening* is one of the focused measures in this group.
  - Interactive Qualtrics educational email sent to Prime and RAE members with a valid email on file in October 2021. Within the email was a field that allowed members to enter the date of their most recent breast cancer screening, or date of surgery that would exclude them from receiving this preventive screening if applicable.
  - MOH message promoting breast cancer awareness played throughout the month of October 2021 to increase member knowledge on the importance of breast cancer screening was placed on member customer service lines for all LOB.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
  - Breast cancer screening was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of October 2021.
  - A Provider Gap Report was sent in October 2021 to healthcare providers identified as having RMHP members who had a breast cancer screening gap.
  - Added Women's Health Annual Care Checklist to Women's Health educational landing page on RMHP website; includes recommended preventive screenings and immunizations.
  - Website provider and member tools—RMHP Clinical Practice Guidelines are posted for reference, Women's Health Annual Care Checklist educational landing page on the RMHP website, and a blog promoting education and awareness about breast cancer screenings.

- For the *Cervical Cancer Screening* measure, mailing activities included:
  - Wellness that Rewards—Cervical Cancer Screening (Prime): Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of cervical cancer screening.

- For the *Cervical Cancer Screening* measure, other activities included:
  - Maternity and Women's Care IQWg focuses on interventions for women's health. *Cervical Cancer Screening* is one of the focused measures in this group.
  - MOH message played during the months of April through June 2022 to promote the importance of cervical cancer screening on member customer service lines for all LOB.
  - *Provider Insider Plus*—January edition included a link to RMHP Clinical Practice Guidelines and May edition included article on cervical cancer screening.
  - Cervical cancer screening was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of March 2022.
  - Cervical cancer screening educational message posted to member and provider portal during the month of May 2022.
  - HPV email sent November 2021 to the parents/guardians of members 9–13 years of age on the importance of receiving and completing the HPV vaccine series. RMHP created and added an HPV Vaccine educational landing page on the rmhp.org website. The email included a link to RMHP's HPV Vaccine landing page.
  - Interactive Qualtrics educational email sent to Prime members with a valid email on file in October 2021. Within the email was a field that allowed members to enter the date of their most recent cervical cancer screening test, or date of surgery that would exclude them from receiving this preventive screening if applicable.
  - Added Women's Health Annual Care Checklist to Women's Health educational landing page on RMHP website; includes recommended preventive screenings and immunizations.
  - Website provider and member tools—RMHP Clinical Practice Guidelines are posted for reference. Women's Health Screening educational landing page on the RMHP website.
- For the *Comprehensive Diabetes Care* measure, mailing activities included:
  - Wellness that Rewards—Comprehensive Diabetes: Incentive and educational mailing brochure through which the member is eligible to receive a gift card upon completion of their diabetes 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.
- For the *Comprehensive Diabetes Care* measure, other activities included:
  - RMHP 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 SDOH 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.

  - Eliza IVR phone outreach to members with diabetes gaps in care occurred in 2021 to engage members in completion of all recommended diabetic tests/screenings and to assist members with scheduling of appointments.
  - Provider gap reports were sent in October 2021 to inform providers of members with no HbA1c testing in 2021 or an HbA1c value greater than 9 percent to provide a reminder on the importance of the member getting recommended diabetes screenings.
  - Provider Education: A Diabetes Toolkit is available for distribution to practices that assists with best practices around care coordination and care management of diabetic members.
  - Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.
  - Diabetes was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of April 2022.
  - Diabetes and Chronic Conditions IQWg focuses on interventions for members with diabetes and chronic conditions. *Comprehensive Diabetes Care* is one of the focused measures in this group.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
  - Quality department RN temps called members with diabetes gaps in October 2021.
  - Diabetes educational message posted to the member and provider portal during the month of April 2022.
  - Diabetes MOH message played during the months of April through June 2022 on member customer service lines for all LOB.
  - CQI team developed diabetes educational one-pager and Kidney Evaluation for Patients with Diabetes (KED) one-pager to disseminate to healthcare providers.
  - Diabetes (oral drugs) is one of the disease states included in the retrospective drug utilization program to address medication adherence.

- For the *Asthma Medication Ratio* measure, activities included:
  - Diabetes and Chronic Conditions IQWg focuses on interventions for members with diabetes and chronic conditions. *Asthma Medication Ratio* is one of the focused measures in this group.
  - Respiratory (inhalers for COPD/asthma) is one of the disease states included in the retrospective drug utilization program.
  - Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.
- For the *Childhood Immunization Status* measure, mailing activities included:
  - New Baby Packet (CHP+ and Prime): Educational brochures mailed to the member's parent or guardian at one 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 (CHP+ and Prime): 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 (CHP+ and Prime): 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 IVR and postcard mailing (RAE, CHP+, and Prime): Children who missed an immunization between 6–18 months of age receive a postcard mailing and IVR call.
  - Annual Care Management Newsletter had information referencing *Childhood Immunization Status* database.
  - Pediatrics IQWg focuses on interventions for the pediatric population. *Childhood Immunization Status* is one of the focused measures in this group.
  - Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
  - WCV for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - Immunizations for children and adolescents MOH message played during the months of January through March 2022 on member customer service lines for all LOB.
  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.
  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having a SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
- For the *Immunizations for Adolescents* measure, mailing activities included:
  - Wellness that Rewards—Pre-Teen Wellness (CHP+ and Prime): Incentive and educational mailing brochure sent to members 10–13 years of age through which the member is eligible to receive a gift card upon completion of an annual wellness visit.
  - Wellness that Rewards—Immunizations for Adolescents (CHP+ and Prime): Incentive and educational mailing brochure sent to members who turned 12 years of age annually through when the member is eligible to receive a gift card upon completion of receiving all three: Tdap, HPV, and Meningococcal vaccines.
- For the *Immunizations for Adolescents* measure, other activities included:
  - Monthly postcard mailing (RAE, CHP+, and Prime): Monthly postcard mailing for adolescents who missed an immunization between 16–18 years of age.

  - HPV vaccine email sent November 2021 to the parents/guardians of members 9–13 years of age on the importance of receiving and completing the HPV vaccine series. RMHP created and added an HPV vaccine educational landing page on the rmhp.org website. The email included a link to RMHP's HPV vaccine landing page.
  - Pediatrics IQWg focuses on interventions for the pediatric population. *Immunizations for Adolescents* is one of the focused measures in this group.
  - Website provider tools—RMHP Clinical Practice Guidelines are posted for reference.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP Clinical Practice Guidelines.
  - WCV for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - Immunizations for children and adolescents MOH message played during the months of January through March 2022 on member customer service lines for all LOB.
  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.
  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having a SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
- For the *Ambulatory Care* measure, activities included:
  - CirrusMD is available to RMHP RAE, Prime, and CHP+ members free of charge. It is a text-based virtual care platform that allows members to connect with a real healthcare provider in seconds, 24/7.
  - Adults' access to preventive/ambulatory health services is a focused measure of the Unattributed Members Workgroup and Preventative and Older Adults IQWg.
  - Annual wellness checklist was sent to providers in the June *Provider Insider Plus* newsletter.
  - RMHP launched an eConsult initiative in Mesa County. The goal of this program is for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc. This eConsult project supports general satisfaction with providers because it may reduce referrals to specialists with long wait times, empowers the primary care practice, and increases education/clinical pathways within primary care. This project will be expanding in FY 2022–2023.
- For the *Follow-Up Care for Children Prescribed ADHD Medication* measure, activities included:
  - Pediatrics IQWg focuses on interventions for the pediatric population. *Follow-Up Care for Children Prescribed ADHD Medication* is one of the focused measures in this group.
  - CQI team created an educational one-pager for providers on follow-up care for children prescribed ADHD medication.

  - RMHP meets with practices during the pediatric medical home forum to present a list of their patients to start working on this measure.

- For the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, activities included:
  - Pediatrics IQWg focuses on interventions for the pediatric population. *Metabolic Monitoring for Children And Adolescents On Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total* are some of the focused measures in this group.

Assessment of Compliance With Medicaid Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems), HSAG identified opportunities for improvement that resulted in the following required actions:

- RMHP Prime was required to update the member liability language in the provider manual to accurately address the various LOB that may have variations in copay and liabilities.
- RMHP Prime was required to update the delegated credentialing agreements that did not include the language required by CMS.

RMHP Prime did not have any required actions for Standard VIII—Credentialing and Recredentialing and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. RMHP Prime submitted the final CAP documents in November 2021. Following the Department's approval, RMHP Prime successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- RMHP Prime confirmed that the health plan verifies its data with providers regularly, including provider surveys and attestations.
- The data sources for both the quarterly network report (NAV) and online directory are the same, but both reflect a moment in time of data that is continually updated.
- The online directory is managed in a manner to present the information for a consumer audience, thus it can reflect provider preferences such as individual versus practice listings. The NAV report is managed in a manner to reflect the requirements of the template.

Encounter Data Validation—MCO 412 Audit Over-Read

RMHP Prime reported that its network department developed a one-page summary that was shared in the provider newsletter and trainings. During internal meetings, RMHP Prime posted the MCO 412 results to discuss current encounter reports and whether there is a need for more ongoing proactive staff education and collaboration between benefit configuration, provider network management, claims, and the audit team.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, RMHP Prime reported engaging in the following QI initiatives:

- Implemented a process to notify PR, who will follow up with the provider, and the VBCRC when customer service is informed by members that a healthcare provider is not accepting new patients or is requiring applications for acceptance.
- Integrated BH components in RAE value based contracts.
- Educated members on the importance of having a primary care relationship with a PCP during welcome calls and offered to help members find a PCP if they do not have one.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, through mailers and emails; the addition of QR codes to existing mailers; and business cards for care coordinators and external stakeholders to distribute.
- Increased provider awareness of the CAHPS survey and encouraged PCPs to deliver high-quality, patient-centered care through the discussion of a CAHPS educational video series with practices and the distribution of the video on the RMHP Prime website.
- Included member experience topics (e.g., leadership training, BH skills training, care management training, MA skills and training, telehealth visits) in newsletter articles, learning collaborative events, and webinar series.

- Provided cultural competency training to providers at care management training and BH skills training.
- Launched an eConsult initiative in Mesa County for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc., which may reduce referrals to specialists with long wait times, empower the primary care practice, and increase education/clinical pathways within primary care.
- Implemented a structure within the RAE value-based contracts where practices are held accountable to CAHPS scores to support practices in patient experience strategies that may yield positive CAHPS results and satisfaction with providers year over year.
- Offered several programs, tools, and resources to help practices implement QI initiatives that aim to improve member outcomes on several high-priority measures so members will be well received by providers and can be sustained long term through the CQI team in collaboration with Integrated Quality Workgroups.

Quality Improvement Plan

To follow up on recommendations related to the FY 2020–2021 QUIP, RMHP Prime reported that the network department developed a one-page BH billing reference sheet, which was shared in the RMHP Prime provider newsletter and trainings. RMHP Prime staff members reported meeting to discuss encounter reports and any need for proactive staff education and collaboration between benefit configuration, provider network management, claims, and the audit team.

Mental Health Parity Audit

In the FY 2020–2021 MHP Audit, RMHP Prime achieved 100 percent compliance. However, HSAG recommended the Department encourage RMHP Prime to evaluate documentation protocols when evaluating if a request for service is a new or concurrent request to ensure accuracy and that the requests are processed using the correct time frame. All RMHP Prime clinical staff members received monthly refresher trainings on aspects of authorization input to ensure appropriate selection when an authorization is created. Additionally, each month a random sample of cases were pulled for an audit conducted by supervisors for each UM staff member. If issues were identified during the audit, the UM staff member received additional 1:1 coaching.

Quality of Care Concern Audit

FY 2021–2022 was the first year HSAG conducted the QOCC Audit with the Colorado RAEs and MCOs; therefore, this section is NA for RMHP Prime.

Appendix A. MCO Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for MY 2021 for measures with a hybrid option, along with the percentile ranking for each MY 2021 hybrid rate. Please note that only measures with the same age stratifications between the HEDIS specifications and the Core Set specifications are included.

Table A-1—MY 2021 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Benchmark Ranking
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Postpartum Care	70.66%	77.86%	50th–74th
Timeliness of Prenatal Care	79.51%	88.56%	50th–74th

Table A-2 shows RMHP Prime's rates for MY 2021 for measures with a hybrid option, along with the percentile ranking for each MY 2021 hybrid rate.

Table A-2—MY 2021 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measure	Administrative Rate	Hybrid Rate	Benchmark Ranking
Primary Care Access and Preventive Care			
Cervical Cancer Screening			
Cervical Cancer Screening	42.34%	61.22%	50th–74th
Childhood Immunization Status			
Combination 3	NA	NA	NA
Combination 7	NA	NA	NA
Combination 10	NA	NA	NA
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	64.71%	64.71%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	8.82%	8.82%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	12.32%	83.69%	75th–89th
Counseling for Nutrition—Total	21.83%	81.91%	75th–89th
Counseling for Physical Activity—Total	2.82%	76.24%	75th–89th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Postpartum Care	36.95%	80.37%	75th–89th
Timeliness of Prenatal Care	56.53%	91.78%	75th–89th