COLORADO

Department of Health Care Policy & Financing

FY 2022–2023 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

January 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Report Purpose and Overview

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations at Title 42 of the Code of Federal Regulations (42 CFR) §438.356 require states to contract with an external quality review organization (EQRO), and 42 CFR §438.358 requires the EQRO to aggregate and analyze results in an annual detailed technical report pursuant to §438.364 that summarizes findings on quality, timeliness, and access to healthcare services that managed care entities (MCEs) furnish to the State's Medicaid and CHIP members. The end product of this analysis is the annual EQR technical report. The Colorado Department of Health Care Policy & Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to comply with these regulations. This annual EQR technical report includes results of all mandatory and optional EQR-related activities that HSAG conducted with Colorado's Medicaid health plans throughout fiscal year (FY) 2022–2023.

Colorado's Medicaid Managed Care Program

Health First Colorado, Colorado's Medicaid program, is comprised of seven Regional Accountable Entities (RAEs) and two managed care organizations (MCOs). In 2011, the Department established the Accountable Care Collaborative (ACC) Program as a central part of Colorado's plan for Medicaid reform. Effective July 1, 2018, the Department implemented ACC Phase II and awarded contracts to the seven RAEs. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service (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 primary care case management (PCCM) entities and prepaid inpatient health plans (PIHPs), and as such are required to comply with Medicaid managed care regulations at 42 CFR Part 438. FY 2022–2023 was the fifth year of RAE operations. Colorado's two MCOs provide services under a capitated contract with the Department. The RAEs and DHMP provide physical health (PH) and mental health (MH) services under a 1915b waiver and substance use disorder (SUD) services under an 1115 waiver. RMHP Prime provides services under Colorado's 1915b waiver.

Colorado's Medicaid MCEs are as follows.

Table 1-1—Colorado Medicaid Health Plans

Medicaid RAEs	Services Provided
Region 1—Rocky Mountain Health Plans (RMHP) Region 2—Northeast Health Partners (NHP) Region 3—Colorado Access (COA Region 3) Region 4—Health Colorado, Inc. (HCI) Region 5—Colorado Access (COA Region 5)	MH inpatient and outpatient services, SUD inpatient and outpatient services, and coordination of both PH and BH services for adults and children enrolled in Medicaid.

Medicaid RAEs	Services Provided
Region 6—Colorado Community Health Alliance (CCHA Region 6) Region 7—Colorado Community Health Alliance (CCHA Region 7)	
Medicaid MCOs	**Services Provided**
Denver Health Medical Plan (DHMP)	PH primary, inpatient, outpatient, specialty, and acute care for a subset of adult and child RAE Region 5 members. MH and SUD inpatient and outpatient services for a subset of RAE Region 5 members.
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	PH primary, inpatient, outpatient, specialty, and acute care for a subset of RAE Region 1 members.

Scope of EQR Activities for Colorado's MCEs

Table 1-2 shows the mandatory and optional EQR-related activities HSAG conducted in FY 2022–2023.

Table 1-2—FY 2022–2023 EQR Activities Conducted

Activity Description/Protocol Number	Participating MCEs
Mandatory Activities	
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.	RAEs and Medicaid MCOs
Validation of Performance Measures (PMV) (Protocol 2)	
HSAG validated performance measures, used for the behavioral health incentive program (BHIP), to assess the accuracy of performance measures reported by the RAEs. The validation also determined the extent to which performance measures, which were calculated by the Department, followed specifications as stated in the Department's RAE BHIP specifications document.	RAEs
HEDIS/Centers for Medicare & Medicaid Services (CMS) Core Set Measure Rate Validation (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.	Medicaid MCOs
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.	RAEs and Medicaid MCOs

Activity Description/Protocol Number	Participating MCEs
Validation of Network Adequacy (NAV) (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. For the provider directory validation (PDV) activity, HSAG validated the MCEs' online provider directories to determine if the information on the MCEs' online provider directories matched the provider data submitted to HSAG by the MCEs.	RAEs and Medicaid MCOs
Optional Activities	
Encounter Data Validation (EDV)—RAE 411 Over-Read (Protocol 5)	
HSAG sampled records audited by the RAEs and DHMP during the MCEs' own encounter data audit. HSAG conducted an over-read of the sampled records to validate the MCEs' EDV results. HSAG reviewed the encounter data to ensure that medical record documentation supported the MCEs' encounter data submissions to the Department.	RAEs and DHMP
EDV—MCO 412 Over-Read (Protocol 5)	
HSAG sampled records audited by the Medicaid MCOs during the MCOs' own encounter data audit. HSAG conducted an over-read of the sampled records to validate the MCOs' EDV results. HSAG reviewed the encounter data to ensure that medical record documentation supported the MCOs' encounter data submissions to the Department.	Medicaid MCOs
CAHPS Surveys—RAEs (Protocol 6)	
HSAG annually administers the CAHPS 5.1 Adult and Child Medicaid Health Plan Survey with the HEDIS supplemental item set to adult Medicaid members and parents/caretakers of child Medicaid members enrolled in the seven RAEs. HSAG calculated and validated the adult and child survey results included in this report.	RAEs
CAHPS Surveys—MCOs (Protocol 6)	
Each MCO was responsible for conducting a CAHPS survey of its members and forwarding the data to HSAG for the calculation and validation of the results included in this report.	Medicaid MCOs
Quality Improvement Plans (QUIPs) (Protocol 8)	
Following the EDV 411 and 412 over-read audits, each health plan is required to design a QUIP to target findings of low encounter data accuracy or low agreement results (under 90 percent) within its own service coding accuracy reports and HSAG's over-read. HSAG tracks and monitors each QUIP to ensure the improvement interventions are appropriately designed and outcomes achieve increased accuracy in encounter data submissions.	RAEs and Medicaid MCOs
Mental Health Parity (MHP) Audits (Protocol 9)	
HSAG monitors the MCEs annually 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.	RAEs and Medicaid MCOs

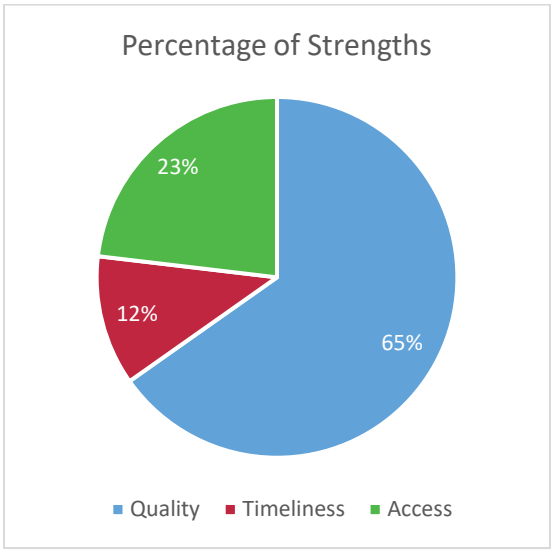
Activity Description/Protocol Number	Participating MCEs
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Audits (Protocol 9)	
HSAG conducted a document review and record review to determine compliance with federal and state-specific EPSDT regulations and contract requirements regarding authorization of services covered under EPSDT and outreach requirements.	RAEs and DHMP
SUD UM Over-Read (Protocol 9)	
In accordance with Senate Bill (SB) 21-137 Section 11, HSAG audited 33 percent of all denials of requests for authorization for inpatient and residential SUD services.	RAEs and DHMP
EQR Dashboard (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.	RAEs and Medicaid MCOs

This report includes the results of EQR-related activities conducted for the MCEs in FY 2022–2023. Colorado does not exempt any of its MCEs from EQR.

Summary of FY 2022–2023 Statewide Performance Related to Quality, Timeliness, and Access

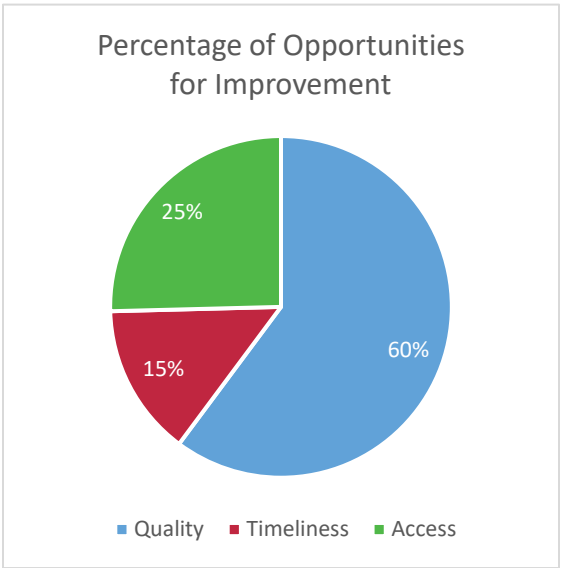
Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed as likely to impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted for all Health First Colorado MCE types during FY 2022–2023.

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—Percentage of Opportunities for Improvement by Care Domain*



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

Statewide Recommendations Related to Quality, Timeliness, and Access

The MCEs demonstrated moderate to strong compliance and performance for EQR activities such as Validation of Performance Improvement Projects, Assessment of Compliance With Medicaid Managed Care Regulations, Validation of Network Adequacy, Encounter Data Validation, Quality Improvement Plans, Mental Health Parity Audit, and Quality of Care (QOC) Concerns Audit. However, HSAG identified opportunities for improvement in the Validation of Performance Measures and CAHPS Surveys EQR activities. As each EQR activity is comprised of multiple strengths and opportunities for improvement, HSAG noted similarities between the percentage of strengths and opportunities for improvement across quality, timeliness, and access; there was low variation in the range of strengths across the MCEs, which ranged from 41 to 49 per MCE for quality, five to 11 for timeliness, and 12 to 20 for access. HSAG noted that the two Medicaid MCOs had the lowest number of strengths related to access and the most variation in strengths and weaknesses.

For detailed statewide findings and recommendations, see Section 3—Statewide Comparative Results, Assessment, Conclusions, and Recommendations. For detailed MCE-specific findings and recommendations, see Section 4—Evaluation of Colorado's Medicaid Managed Care Health Plans.

2. Reader's Guide

How This Report Is Organized

Section 1—Executive Summary provides the purpose and overview of this annual EQR technical report, includes a brief introduction to Health First Colorado, and describes the authority under which Colorado's MCEs provide services. This section also describes the EQR activities conducted during FY 2022–2023 and includes graphics that depict the percentages of strengths and opportunities for improvement—derived from conducting mandatory and optional EQR activities in FY 2022–2023—that relate to the care domains of quality, timeliness, and access. In addition, this section includes any conclusions drawn and recommendations made for statewide performance improvement.

Section 2—Reader's Guide describes the background of federal regulations and the authority under which the report must be provided; 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, timeliness, and accessibility of care provided by Colorado's Medicaid managed care health plans.

Section 3—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. In addition, this section includes 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, timeliness, and accessibility of healthcare provided by the Medicaid health plans.

Section 4—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, timeliness, and accessibility of care and services for each health plan as applicable to the activities performed and results obtained. This section also provides for each health plan, 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 2021–2022 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, timeliness, and access to care and services.

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP [prepaid ambulatory health plan], or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[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 healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—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 quality improvement (QI) strategies and activities the health plans conducted during the PIP. HSAG's scoring methodology evaluated whether the health plan executed a methodologically sound PIP.

Technical Methods of Data Collection

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

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

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus

baseline data collection specifications and methodology are defined, and the MCO sets aims (Global and SMART [Specific, Measurable, Achievable, Relevant, Time-Bound]), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.

- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the QI activities reasonably expected to impact the SMART Aim. The MCO updates the key driver diagram from Module 1 after completing process mapping, failure 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 2022–2023, these forms provided detailed information on the PIPs and the activities completed for Module 4—PIP Conclusions.

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 a revised Module 4, if needed.

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* PIP.

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
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

RAE	SMART Aims	Data Sources
	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
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%.	Electronic health record (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
COA Region 3	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
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 15.00%.	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 30.00%.	Claims and enrollment data
COA Region 5	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

RAE	SMART Aims	Data Sources
CCHA Region 6	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
CCHA Region 7	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 58.95%.	Enrollment data, claims data, and EMR data
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 20.00%.	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 scores each PIP on a series of evaluation elements and scores 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 completes intervention testing and submits Module 4 and the completed PDSA worksheets for validation, HSAG reviews the PDSA worksheet documentation and score evaluation elements for Module 4 as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigns a level of confidence to the PIP after completing validation of Module 4 submission.

How Conclusions Were Drawn

HSAG, as the State's EQRO, validates the PIPs through an independent review process. In its PIP evaluation and validation, HSAG uses 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 are not scored. As the PIP progresses, HSAG uses the validation findings from modules 1 through 4 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigns a level of confidence and reports the overall validity and reliability of the findings as one of the following:

- ***High confidence:*** The PIP is 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.
- ***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.

[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: Nov 29, 2023.

- ***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, timeliness, and accessibility of 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 determined that all PIPs were related to the quality domain. All health plans conducted a PIP related to the same topic—*Depression Screening and Follow-Up After a Positive Depression Screen*. HSAG determined that this PIP topic also related to the access and timeliness domains of care.

Validation of Performance Measures for RAEs

Objectives

The primary objectives of the performance measure validation (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 measurement year (MY) 2022 (i.e., July 1, 2021, through June 30, 2022) performance measures be validated during FY 2022–2023 based on the specifications outlined in the *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2021–2022*, 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 2021–2022 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 (CMS EQR Protocol 2),[2-3] and were used to improve the efficiency of validation work performed.

[2-2] Colorado Department of Health Care Policy and Financing. *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2021–2022.*

[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: Nov 29, 2023.

- Developed an Information Systems Capabilities Assessment Tool (ISCAT) that was customized to Colorado's service delivery system and was used to collect the necessary background information on the Department's information systems (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 2022–2023 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

To draw conclusions about the quality, timeliness, and accessibility of care provided by the RAEs, HSAG determined that each of the measures validated were related to one or more of the three domains of care (quality, timeliness, or access). This relationship of the measures to the domains of care is depicted in Table 2-2.

Table 2-2—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 Emergency Department (ED) Visit for SUD	✓	✓	✓
Follow-Up After a Positive Depression Screen	✓	✓	✓
Behavioral Health Screening or Assessment for Children in the Foster Care System	✓	✓	✓

The RAE's MY 2022 performance measure rates were compared to the Department's established performance targets and are denoted in Table 2-3.

Table 2-3—MY 2022 Performance Targets

Performance Measure	Performance Target*
Engagement in Outpatient SUD Treatment	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	77.74%
Follow-Up Within 7 Days of an ED Visit for SUD	40.14%
Follow-Up After a Positive Depression Screen	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	36.42%

**Performance targets are specified in the Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2021–2022.*

HEDIS/Core Set Measure Rates 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 (LOBs). 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 and activities constitute the standard practice for HEDIS audits in MY 2022 regardless of the auditing firm. These processes and 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 site review meetings 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.

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

  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS 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 2022 rates as presented within the custom rate reporting template completed by the health plan or its contractor.

The MCOs were responsible for obtaining and submitting their respective HEDIS final audit reports (FARs) to HSAG. The HEDIS auditor's responsibility was to express an opinion on each MCO's 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 2022 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 required measures for reporting had a "pass" status.
3. **Rate Files From Previous Years and Current Year:** Final rates provided by health plans in a custom rate reporting template 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 federal fiscal year (FFY) 2023 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 and custom rate 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 the performance measure results tables, HEDIS rates shaded green with one caret (^) indicate statistically significant improvement in performance from MY 2021 to MY 2022. HEDIS rates shaded red with two carets (^^) indicate statistically significant declines in performance from MY 2021 to MY 2022. 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 custom rate reporting template 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 2022 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2021, 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 2022 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 2021.
  - Ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2021.
- 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 2021.

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 2020, MY 2021, and MY 2022 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 2-4 presents the measures in this report that can be reported using the hybrid methodology.

Table 2-4—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
Immunizations for Adolescents
Developmental Screening in the First Three Years of Life
Lead Screening in Children
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

HEDIS Measures
Maternal and Perinatal Health
Prenatal and Postpartum Care
Care of Acute and Chronic Conditions
Controlling High Blood Pressure
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes
Behavioral Health Care
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MCOs, HSAG determined that each of the performance measures were related to one or more of the three domains of care (quality, timeliness, or access). This relationship between the measures and the domains of care is depicted in Table 2-5.

Table 2-5—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	✓		
Lead Screening in Children	✓	✓	
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	✓		

Performance Measure	Quality	Timeliness	Access
Concurrent Use of Opioids and Benzodiazepines	✓		
Controlling High Blood Pressure	✓	✓	
HbA1c Control for Patients With Diabetes	✓		
Human Immunodeficiency Virus (HIV) Viral Load Suppression	✓		
Use of Opioids at High Dosage in Persons Without Cancer	✓		
Plan All-Cause Readmissions	✓		
Behavioral Health Care			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Antidepressant Medication Management	✓		
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 Emergency Department Visit for Substance Use	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓
Initiation and Engagement of Substance Use Disorder Treatment	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Screening for Depression and Follow-Up Plan	✓		✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Pharmacotherapy for Opioid Use Disorder	✓	✓	✓
Use of Services			
Ambulatory Care: Emergency Department Visits	NA	NA	NA
Plan All-Cause Readmissions	✓		
PQI 01: Diabetes Short-Term Complications Admission Rate	✓		
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	✓		

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 4, MY 2020, MY 2021, and MY 2022 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 2020, MY 2021, and MY 2022, 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 2-6 describes the standards and associated regulations and requirements reviewed for each standard.

Table 2-6—Compliance Standards

Standard Number and Title	Regulations Included	Year Reviewed
Standard I—Coverage and Authorization of Services	438.114 438.210	2022–2023
Standard II—Adequate Capacity and Availability of Services	438.206 438.207	2019–2020 2022–2023
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	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424	2019–2020 2022–2023
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 Number and Title	Regulations Included	Year Reviewed
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	2022–2023

For the FY 2022–2023 compliance review process, the standards reviewed were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

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, timeliness, and accessibility of 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, timeliness, or accessibility of 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 2-7 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-7—Protocol Activities Performed for Assessment of Compliance With Regulations

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	The Department directed HSAG to conduct all compliance monitoring activities virtually. HSAG used web-based conferencing to conduct the FY 2022–2023 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. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the 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 web-based 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.

[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: Nov 5, 2023.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Virtual Compliance Review**
	• During the interview portion of the review, HSAG met with each 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 plans and the Department for review and comment. • HSAG incorporated the health plans' 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 3) 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, timeliness, and accessibility of care and services provided by the Medicaid health plans, HSAG determined that each standard reviewed for assessment of compliance was related to one or more of the domains of care (quality, timeliness, or access). Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table 2-8 depicts the relationship between the standards and the domains of care.

Table 2-8—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Adequate Capacity and Availability of Services	✓	✓	✓
Standard VI—Grievance and Appeal System	✓	✓	
Standard XII—Enrollment and Disenrollment	✓		✓

Validation of Network Adequacy

HSAG conducted two distinct activities in FY 2022–2023 designed to assist the Department in understanding the adequacy of the provider networks across the State: time and distance analysis and PDV.

Objectives

Time and Distance Analysis

The purpose of the FY 2022–2023 network adequacy validation (NAV) time and distance analysis was to determine the extent to which HSAG agreed with the MCEs' self-reported compliance with minimum time and distance network requirements applicable to each MCE. CMS recently released the EQR NAV protocol in February 2023. While the FY 2022–2023 NAV activity was designed to be a robust validation of Colorado's network adequacy and was executed in alignment with the federal regulations in place at the time of the activity, the contents of this report do not reflect activities described in the recently published

CMS protocols. The activities described in the protocol must be implemented beginning in February 2024 and included in the analysis for the EQRO technical reports due in April 2025.

Provider Directory Validation

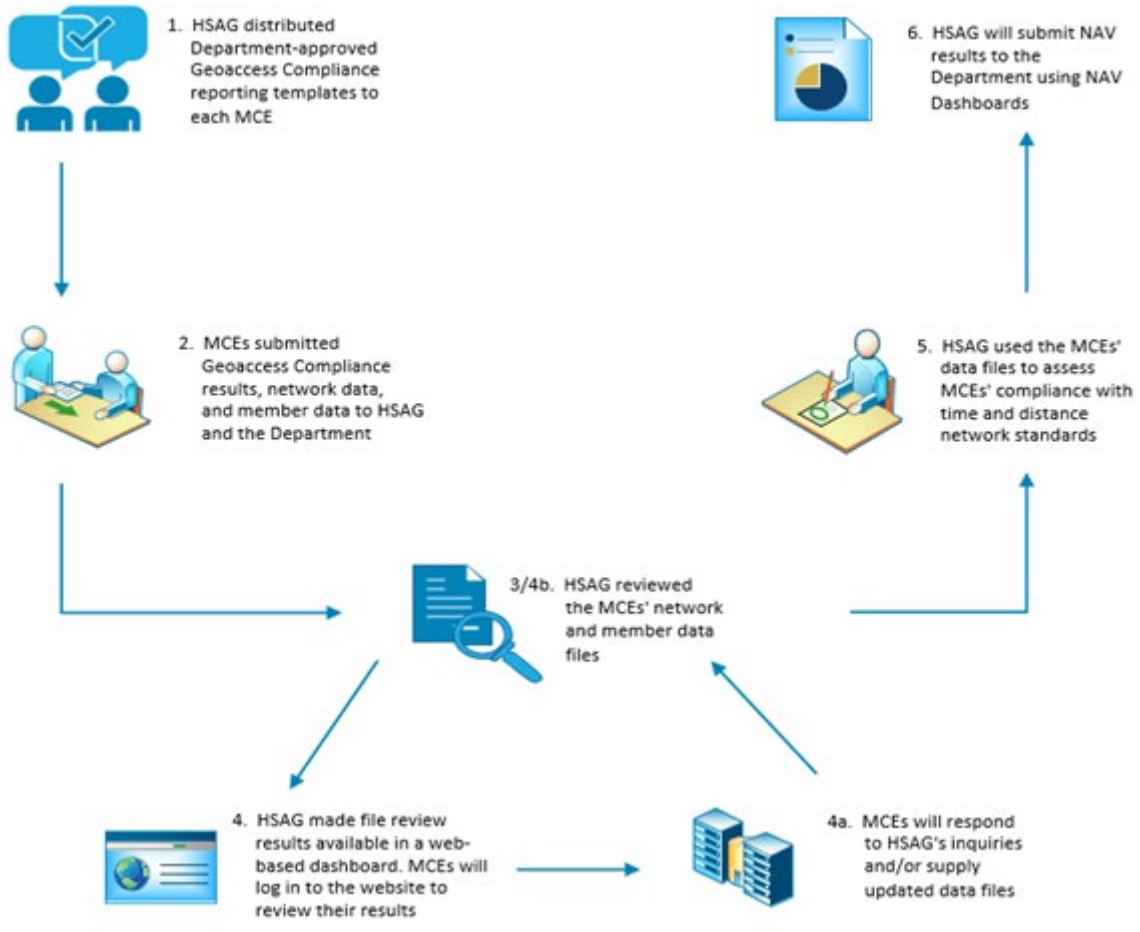
The goal of the FY 2022–2023 PDV was to determine if the information on the MCEs' online provider directories matched the provider data submitted to HSAG by the MCEs.

Technical Methods of Data Collection

Time and Distance Analysis

Beginning in the upper left corner, Figure 2-1 describes the key steps in HSAG's process for quarterly NAV time and distance analysis.

Figure 2-1—Summary of FY 2022–2023 Process for Time and Distance Analysis



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

HSAG provided the Department-approved geoaccess compliance templates and requested provider network and member data from each MCE. HSAG reviewed each MCE's provider 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 MCE 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. The provider types (e.g., physician, medical doctor) and specialties (e.g., cardiology, family medicine) listed in the Network Crosswalk are based on MCE data values observed by HSAG. Each MCE was instructed to review its network data values to ensure alignment with the Department's provider categories (e.g., Pediatric Primary Care Practitioner [MD, DO, NP, CNS], General Behavioral Health). 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 2-9 presents the provider categories applicable to MCOs and RAEs; within each category, FY 2022–2023 NAV analyses were limited to categories corresponding to the MCEs' minimum time and distance network requirements.

Table 2-9—Provider Categories by MCE Type

Provider Categories	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*)		✓

In FY 2022–2023, HSAG collaborated with the Department to enhance and maintain a Network Crosswalk and quarterly network adequacy reporting materials, with the goal of standardizing the MCEs' quarterly network adequacy reports and network data collection to facilitate the EQRO's

[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: Nov 29, 2023.

[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); BH (MH and SUD), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

validation of the MCEs' network adequacy results. On December 15, 2022, HSAG notified each MCE of the January 31, 2023, deadline to submit the FY 2022–2023 Quarter 2 (Q2) network adequacy report and data files. Each MCE's notification included detailed data requirements and a MCE-specific Network Adequacy Quarterly Geoaccess Results Report template containing the MCE's applicable network requirements and contracted counties. To support consistent network definitions across the MCEs and over time, HSAG supplied the MCEs with the Department-approved December 2022 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

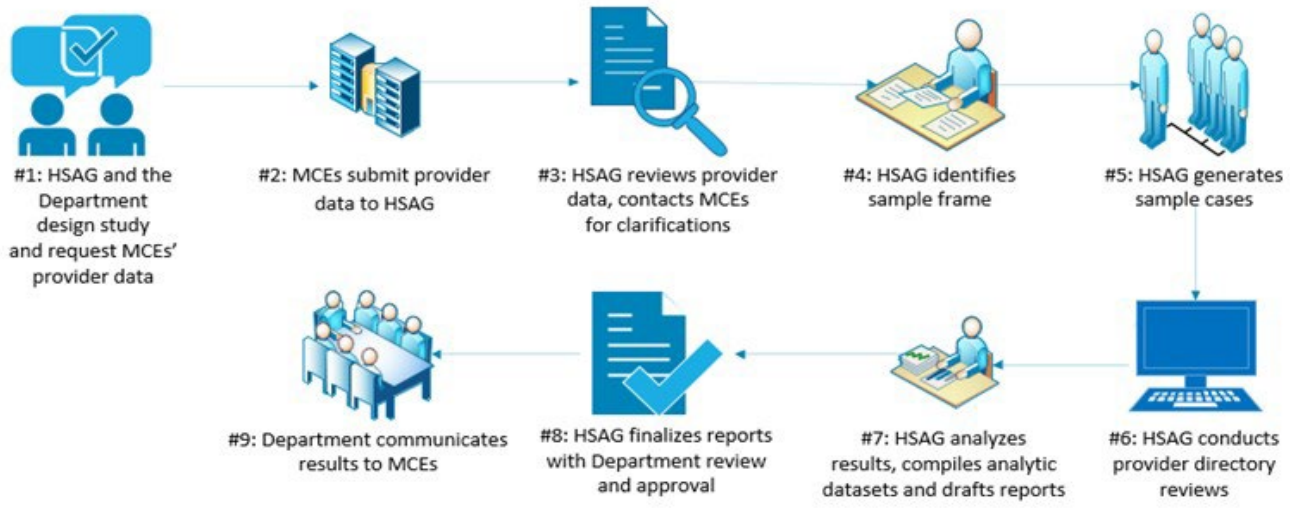
Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid member and network files from the Department for members enrolled with a MCE and practitioners, practices, and entities enrolled in *interChange*.[2-8] HSAG requested Medicaid member files from the Department using a detailed member data requirements document for members actively enrolled with a MCE as of December 31, 2022, for FY 2022–2023 Q2. During FY 2022–2023, HSAG used the Department's member and network data each quarter within the enhanced file review process to assess the completeness of the MCEs' member data submissions (e.g., comparing the number of members by county between the two data sources).

The Department used the FY 2022–2023 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.

[2-8] *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.

Provider Directory Validation

Figure 2-2—Summary of FY 2022–2023 Process for PDV



Using the October 31, 2022, quarterly provider data file, which represented practitioners that were actively enrolled in the Health First Colorado program as of September 30, 2022, HSAG sampled 411 practitioners (i.e., "cases") for each MCE from the eligible population. Cases were sampled by unique provider and address (i.e., validation was performed for a provider for the sampled location), and only counties in which each MCE had attributed members were included.

Description of Data Obtained

Time and Distance Analysis

Quantitative data for the study included member-level data from the Department and member and provider 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 member and provider network files from the Department for members enrolled with an MCE and practitioners, practices, and entities enrolled in *interChange*.

During the FY 2022–2023 NAV, HSAG also used the Department's member data to compare against the MCEs' member data files (e.g., demographic information and member counts).

Provider Directory Validation

HSAG used the October 31, 2022, quarterly provider data file, which represented practitioners that were actively enrolled in the Health First Colorado program as of September 30, 2022, to select the PDV samples. Table 2-10 presents the specialty categories[2-9] that were eligible for sampling for each MCE.

Table 2-10—Specialty Categories by MCE Type

Specialty Category	RAE	MCO
General Behavioral Health, Adult and Pediatric (BV102, BV103, BV104, BV120, BV121, BV130, BV131, BV132, BG126, BG127)	✓	✓
Psychiatric and Other Psychiatric Prescribers, Adult and Pediatric (BV100, BV101, BG110, BG111, BG112)	✓	✓
Substance Use Disorder (SUD) Treatment Practitioners, Adult and Pediatric (BV080)	✓	✓
SUD Treatment Facilities (all American Society of Addiction Medicine [ASAM] levels of care [LOCs]), Adult and Pediatric (BF085)	✓	✓
Psychiatric Hospitals, Units and Acute Care, Adult and Pediatric (BF140, BF141)	✓	✓

How Data Were Aggregated and Analyzed

Time and Distance Analysis

HSAG used the MCEs' member and provider network data to calculate time/distance and compliance mismatch results for each MCO and RAE for each county in which the MCE had at least one member identified in the MCE's member data file during FY 2022–2023 Q2. HSAG evaluated two dimensions of access and availability: compliance mismatch (i.e., HSAG did not agree with the MCE'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 MCEs' member and provider network data files. Within the MCEs' provider 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 MCEs' prior quarterly data submissions.

[2-9] The network category codes that were used to identify each provider type are included in parentheses.

HSAG also used the Department's member data to assess the completeness and reasonability of the MCEs' member data files (e.g., assessing the proportion of members residing outside of a MCE's assigned counties and comparing the results to prior quarters' data). Following initial data quality review, HSAG refreshed the NADIV dashboard with data results quarterly. Each MCE was provided access to the NADIV dashboard, an interactive tool through which the initial file review findings were summarized. Alongside the summary of findings, HSAG stated whether clarifications and/or data file resubmissions were required.

Following the initial data review and HSAG's receipt of the MCEs' 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 2023.1 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 MCEs, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[2-10] HSAG used the counties listed in the MCEs' 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 MCE 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.

Provider Directory Validation

For each sampled case, HSAG compared the MCEs' provider data values to the information on the MCEs' online provider directory for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Practitioner's Name or Business Name
- Address: Street Address
- Address: Suite Number
- Address: City
- Address: State

[2-10] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2022. Available at: https://coruralhealth.org/wp-content/uploads/2013/10/2022-county-designations.pdf. Accessed on: Nov 29, 2023.

- Address: ZIP Code
- Telephone Number
- Practitioner Type/Specialty (matches the sampled practitioner specialty category)
- Accepting New Patients
- Practitioner Gender[2-11]

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the quarterly provider data extract.
- No, the information did not match between the online provider directory and the quarterly provider data extract.
- Not listed in directory, the information was listed in the MCE provider data, but not listed in the online provider directory. This response applied to the following indicators: practitioner type/specialty, accepting new patients, and practitioner gender.

How Conclusions Were Drawn

Time and Distance Analysis

HSAG used the RAEs' and Medicaid MCOs' quarterly geoaccess compliance reports and member and provider data to perform the geoaccess analysis specific to each MCE. HSAG reviewed the results of the compliance mismatch analysis to identify the percentage of results where HSAG agreed with the MCE's geoaccess compliance results, stratified by county designation. HSAG reviewed the results of the analysis of time and distance requirements 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. HSAG determined that the NAV activities provided insight into the access domain of care.

Provider Directory Validation

To draw conclusions about the quality and accessibility of care and services that each MCE provides to its members, HSAG analyzed the results of the PDV activity to determine each MCE's strengths and weaknesses by assessing the degree to which the MCEs' online provider directory information is accurate, up to date, and easy to locate and navigate.

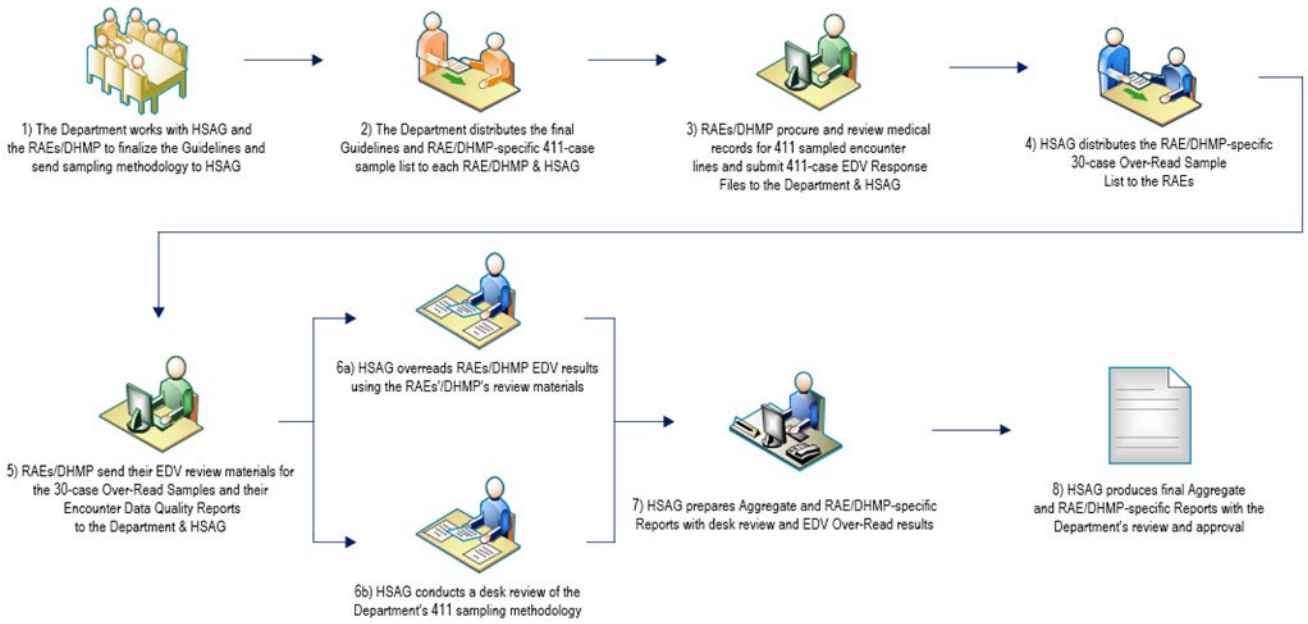
[2-11] The "Practitioner Gender" indicator was not assessed for facilities.

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 2-3 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 2-3—FY 2022–2023 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 Reports. To support the BH EDV, the Department selected a random sample of 411 final, paid encounter lines with dates of service between July 1, 2021, and June 30, 2022, 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 overread each RAE's and DHMP's EDV results using MRR among a random sample of each 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

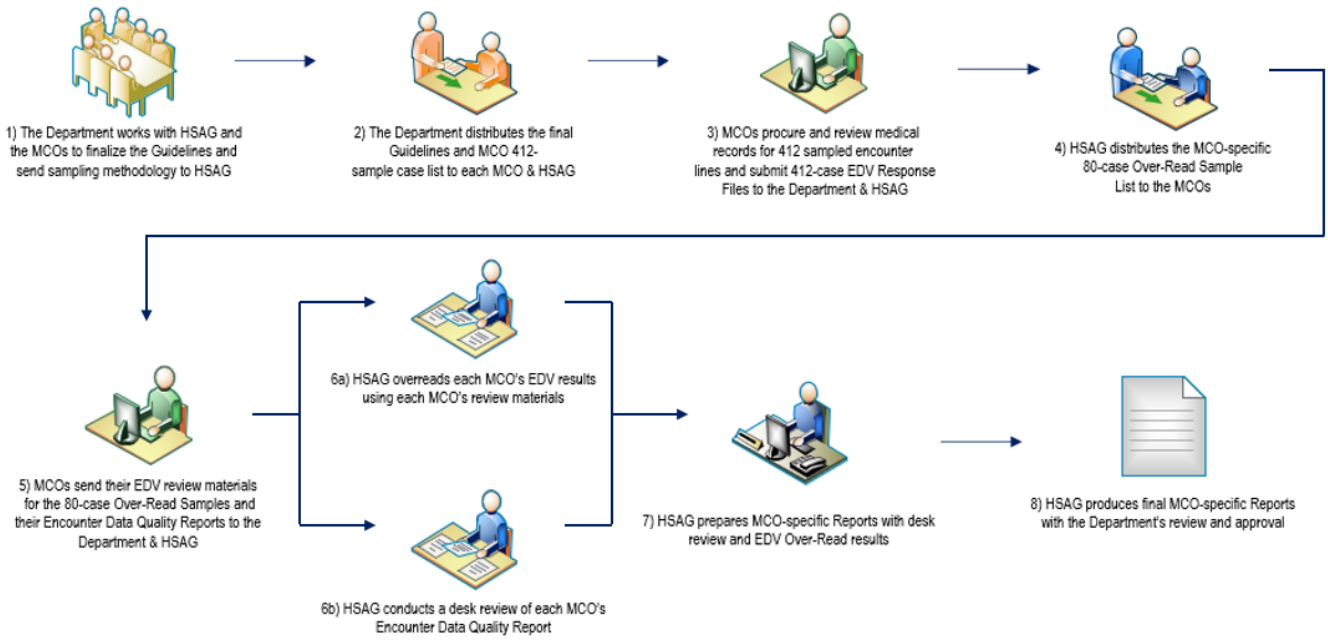
HSAG's over-read evaluated whether the RAEs' and DHMP's internal validation results were consistent with Colorado's Uniform Service Coding Standards (USCS) manuals and standard coding practices specific to the study period. Based on HSAG's level of agreement with each RAE's and DHMP's EDV results for 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 Over-Read

Objectives

The MCO 412 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 2-4 diagrams the high-level steps involved in HSAG's 412 EDV over-read process, beginning in the upper left corner of the image.

Figure 2-4—FY 2022–2023 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, 2021, through June 30, 2022, and paid dates between July 1, 2021, and September 30, 2022. 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 overread each MCO's EDV results using MRR among a random sample of the MCO's 412 EDV cases. HSAG randomly selected 20 encounter lines in each of the four service categories, resulting in an over-read sample of 80 cases per MCO.

Description of Data Obtained

The Department used encounter data submitted by each MCO to generate the 412 sample lists, and HSAG sampled the over-read cases from the 412 sample lists. Each MCO was responsible for procuring medical records and supporting documentation for each sampled case, and the MCOs used these materials to conduct their internal validation. Following its 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 the healthcare they/their child received.

Technical Methods of Data Collection

The technical method of data collection for the RAEs occurred through the administration of the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population and the CAHPS 5.1 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, 2022. Child members included as eligible for the survey were 17 years of age or younger as of October 31, 2022. All sampled adult members and parents/caretakers of sampled child members completed the surveys from

December 2022 to May 2023. 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 the other 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, MCEs, 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

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 followed NCQA methodology when calculating the results.

HSAG performed a trend analysis of the results in which the FY 2022–2023 scores were compared to their corresponding FY 2021–2022 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2022–2023 top-box scores and the FY 2021–2022 top-box scores are noted with directional triangles. A RAE's top-box score that was statistically significantly higher in FY 2022–2023 than FY 2021–2022 is noted with a green upward (▲) triangle. A RAE's top-box score that was statistically significantly lower in FY 2022–2023 than FY 2021–2022 is noted with a red downward (▼) triangle. A RAE's top-box score that was not statistically significantly different between years 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 a green upward (↑) arrow. A RAE's top-box score that was statistically significantly lower than the NCQA national average is noted with a red downward (↓) arrow. A RAE's top-box score that was not statistically significantly different than the NCQA national average is not denoted with an arrow.

In addition, HSAG performed RAE comparisons of the results. Given that differences in case-mix can result in differences in ratings between RAEs that are not due to differences in quality, the data for the RAEs were case-mix adjusted for survey-reported member general health status, member mental or emotional health status, member or parent/caretaker of child member education level, and member or parent/caretaker of child member age to account for disparities in these characteristics; therefore, the RAE comparison results of the seven RAEs may be different than the trend analysis results. Statistically significant differences between the RAEs' top-box responses and the Colorado RAE aggregate are noted with directional arrows. A RAE's top-box score that was statistically significantly higher than the Colorado RAE aggregate is noted with a black upward (↑) arrow. A RAE's top-box score that was statistically significantly lower than the Colorado RAE aggregate is noted with a black downward (↓) arrow. A RAE's top-box score that was not statistically significantly different than the Colorado RAE aggregate is not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of services provided by the RAEs, HSAG determined that each of the measures was related to one or more of the three domains of care (quality, timeliness, or access). This relationship between the measures and the domains of care 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 regarding patients' and parents'/caretakers' of child patients experiences with the healthcare they/their child received.

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 adult members and parents/caretakers of child members to report on and evaluate their/their child's experiences with healthcare. These surveys cover topics important to adult members and parents/caretakers of child 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 4.

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 2022–2023 scores were compared to their corresponding FY 2021–2022 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2022–2023 top-box scores and the FY 2021–2022 top-box scores are noted with directional triangles. An MCO's top-box score that was statistically significantly higher in FY 2022–2023 than FY 2021–2022 is noted with a green upward (▲) triangle. An MCO's score that was statistically significantly lower in FY 2022–2023 than FY 2021–2022 is noted with a red downward (▼) triangle. An MCO's score that was not statistically significantly different between years is not denoted with a triangle.

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 a green upward (↑) arrow. An MCO's top-box score that was statistically significantly lower than the NCQA national average is noted with a red downward (↓) 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, timeliness, and accessibility of services provided by the MCOs, HSAG determined that each of the measures was related to one or more of the three domains of care (quality, timeliness, or access). This relationship between the measures and the domains of care 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 Plan

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 data elements found to be below 90 percent accuracy or 90 percent agreement during the FY 2021–2022 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 data element 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

The 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 (SOP) 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 2022 through January 2023, unless otherwise indicated) with a selected service agency or provider(s). Each month the MCE tracked the accuracy data percentage for each data element. At the conclusion of the three-month evaluation period, each MCE submitted the outcome data for each data element 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 2021–2022. Using these reports, HSAG compiled data for all MCEs with self-reported encounter data accuracy scores below 90 percent accuracy or agreement scores below 90 percent, which is the Department's threshold for required participation in the QUIP. The FY 2021–2022 RAE 411 or MCO 412 EDV self-reported accuracy scores were used as the baseline data for the FY 2022–2023 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 four claim types: inpatient services, psychotherapy services, and residential services. Within each claim type, HSAG and the RAEs calculated accuracy rates for the following audit elements (data elements): *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: inpatient, outpatient, professional, and FQHC. Within each claim type, the MCOs calculated accuracy rates for the following audit elements (data elements): *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 data elements 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, variation in accuracy scores month over month, and the sustainability and reliability of the intervention. A summary of recommendations was 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. HSAG determined that the QUIP projects were related to the quality domain of care.

Mental Health Parity Audit

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
- Utilization review (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 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. HSAG determined that this activity was related to the access and quality domains of care.

EPSDT Services Audit

Objectives

The purpose of the EPSDT services audit was to determine whether the MCEs:

1. Had policies, procedures, trainings, reports, and relevant documents that were aligned with EPSDT federal regulations and specific State requirements.
2. Conducted outreach to EPSDT eligible members who were identified as "non-utilizers" because they had not received any EPSDT services within the 12-month period prior to the annual anniversary date of their enrollment.
3. Included EPSDT considerations when making medical necessity determinations prior to denying authorization for services.

Technical Methods of Data Collection

HSAG distributed a desk request to obtain policies, procedures, and other documentation and to assess each MCE's overall adherence to federal and State requirements related to EPSDT procedures. Additionally, HSAG collected two types of data sets. First, HSAG requested a "non-utilizer" data file from the Department that included a list of all EPSDT eligible members who had been continuously enrolled for a 12-month period ending in Q4 of FY 2021–2022 (April 2022–June 2022) and had not received services during the 12-month period. Second, HSAG requested a denial data file from each MCE to obtain a list of all medical necessity denials for EPSDT eligible members.

Description of Data Obtained

The following are examples of documents reviewed as part of the desk request:

- UM policies, procedures, desktop aids, and other related materials.
- Initial EPSDT informational materials.

- Assessment templates (new member assessment, risk assessment, special health care needs [SHCN], EPSDT, or others commonly used for new members and EPSDT).
- Specific EPSDT considerations.
- Reports such as outreach plans; quarterly outreach reports; and outreach scripts, flyers, birthday letters, etc.
- Referral, care coordination, or UM logs pertaining to EPSDT services.
- EPSDT trainings for the provider network and MCE staff members.
- Notice of adverse benefit determination (NABD) templates.

For each non-utilizer sample, HSAG obtained the following information:

- Member's name, demographic information, healthcare needs, diagnosis, and enrollment anniversary date.
- Health needs survey, health needs assessment, or other screenings and assessments available for the member.
- Evidence of any outreach attempted to obtain new member screening and/or assessment information and reasons the outreach was attempted.
- EPSDT-specific outreach conducted after the member's 12-month enrollment anniversary due to non-utilization of services. The MCE included any associated information and clearly marked if there was more than one attempt, the method of outreach for any attempts, and the outcome of EPSDT-specific outreach.
- Any evidence that the member obtained any services after the outreach attempt. If the member did not obtain services after the outreach, HSAG assessed whether the MCE conducted any additional outreach, and included a description and evidence of any additional outreach attempts.

For each denial sample, HSAG obtained the following information:

- Member name and identification (ID) number.
- Date of service request and date of determination.
- Denial type and denial reason.
- NABD.
- Documentation regarding the service authorization request, member status, and needs.
- UM reviewer notes (each reviewer), including credentials and dates.
- Documentation of communication between UM staff, providers, and members and/or the member's authorized representative.
- Decision maker notes and credentials.
- Care coordination notes, referral notes and logs, and any follow-up communication internally or externally.

How Data Were Aggregated and Analyzed

For each of the eight MCEs, HSAG aggregated, analyzed, and compiled the data results and findings. The process occurred in six phases: 1) desk review, 2) sample selection, 3) record reviews, 4) virtual interviews, 5) analysis, and 6) reporting. From the record reviews and virtual interviews with key personnel, HSAG was able to look for patterns and trends with the data, and identify strengths, opportunities for improvement, and recommendations for each MCE and statewide.

How Conclusions Were Drawn

To draw conclusions, HSAG used the Department-approved desk review template and record review tools to record HSAG's findings regarding each MCE's compliance with EPSDT regulations and specific State requirements. HSAG then analyzed the findings for trends within each MCE and across MCEs and reported the results of HSAG's analysis with recommendations for both the MCEs and the Department.

HSAG determined that this activity was related to the quality and access domains of care.

Substance Use Disorder Utilization Management Over-Read

Objectives

The purpose of the SUD UM over-read was to determine whether the:

1. MCEs properly followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential LOCs.
2. HSAG reviewers agreed with the denial decisions made by each MCE.

Technical Methods of Data Collection

HSAG requested a data file from each MCE to obtain a list of all denials for inpatient hospital and residential levels of SUD treatment among MCE members. Upon receiving the list of all denials from the MCEs, HSAG reviewed key data fields to assess potential duplication, data completeness, and the distribution of denials by MCE, facility, and ASAM LOC. HSAG used the listing of all denied services for inpatient hospital and residential SUD treatment as a sample frame from which to generate a sample list of cases for each MCE for the over-read activities. HSAG used a random sampling approach to select no less than 33 percent of denials that occurred per MCE, based on the number of unique denials for inpatient hospital and residential SUD treatment in the sample frame for each MCE. HSAG ensured that the sample cases reflected the widest possible array of denials among facilities, ASAM LOCs, and members.

Before sampling, HSAG counted the number of denials by MCE for inpatient hospital and residential SUD treatment and determined the number of cases needed to meet the 33 percent requirement. Fractional numbers were rounded up to the nearest whole number of cases to ensure a minimum of

33 percent of denials were reviewed. HSAG then randomly selected a representative sample of denials for each MCE using the number of sample cases identified in the sample size determination. Cases were then proportionately distributed based on the number of denials within each LOC. For example, if 28 percent of an MCE's denials were attributed to the 3.1 ASAM LOC, 28 percent of the MCE's cases chosen for over-read will reflect denials attributed to the 3.1 ASAM LOC.

Description of Data Obtained

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

- Member name, date of birth (DOB), and ID number.
- Date of service request and date of determination.
- Requesting facility (provider) information.
- ASAM LOC requested and LOC approved.
- Length of stay (LOS) requested and LOS approved.
- Denial type and denial reason.
- Whether the denial was appealed, went to a State fair hearing, and the outcome.
- Result of the review (i.e., denied, partial, or limited approval).
- ABD information provided to the member and to the provider.
- Copies of information the MCE used to make the UR denial determination, including notes from each reviewer; dates of each review; system notes associated with each point of the review; and documentation of telephonic and/or written communication between reviewers and UR staff, providers, members, and/or authorized representatives.
- Documentation of how the MCE considered each ASAM dimension using the most recent edition of The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions when determining medical necessity.
- Documentation as to whether medication-assisted treatment (MAT) was provided as part of the treatment provided.
- Credentials of the MCE reviewer who made the denial determination.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, the review of sample case reviews, and determined:

- Whether the information found in the medical records and related documents was sufficient to make an independent UR determination regarding the appropriateness of the prior-authorization request and the accuracy of the MCE determination.
- Whether the MCE reviewer used the appropriate criteria.
- Whether the HSAG reviewer agreed/disagreed with the MCE denial determination.

- Whether clinical denial determinations were made by an MCE reviewer with appropriate credentials and expertise in treating the member's condition.
- Whether potential QOC concerns were documented in the case file.

HSAG analyzed the results to identify strengths, opportunities for improvement, and recommendations. Based on the results of the data aggregation and analysis, HSAG prepared and distributed a draft report to the Department for its review and comment prior to issuing final reports, which the Department submitted to the Senate.

How Conclusions Were Drawn

To draw conclusions, HSAG analyzed the sample record review findings to determine if trends existed for each MCE as well as trends across the eight MCEs. Topics considered in this analysis included the rate of agreement with the use of ASAM criteria, the MCE's denial determination, and assessing for potential QOC concerns.

HSAG used an interrater reliability (IRR) process to sample 10 percent of completed reviews from reviewers and ensure that reviewers maintain 95 percent accuracy of HSAG determinations throughout the review project.

HSAG determined that this activity was related to the quality and access domains of care.

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 sections of this EQR 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 Audits, 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 health plan performance across a number of different EQR activities at a glance.

HSAG developed the following dashboard:

- **Compare Health Plans Overall, by Domain, and by Measure**—This view allows the user to select a program and review how all health plans with the program are performing at a high level. This view also provides results for CAHPS, performance measures, compliance, MHP, and PIPs.

This dashboard allows the user to assess health 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 use the filtered results to determine how an individual health plan within a program performed based on the health plan's Core Set and CAHPS data.

- The *CAHPS Performance by Plan* table represents the health plans' overall performance on CAHPS measures, with five stars indicating a highest performing health plan and one star indicating a lowest performing health plan. Star ratings are available based on a health plan's performance compared to the statewide average and in relation to NCQA Quality Compass national benchmarks.
- The *Compliance* table provides the overall number of metrics in which the statewide standard is met. Additional detail on the specific measure results can be found via the tooltip or by selecting the *Standards* table and the applicable year from the table.
- *MHP* results are provided in a table where a green arrow indicates an improvement in performance from the prior year, while a red arrow indicates a decline in performance. A blue tilde indicates that the score remained unchanged as compared to the previous year.
- The *PIP* results are summarized by module to include the PIP topic, SMART Aim statement, follow-up, status of each module, and confidence level.

Aggregating and Analyzing Statewide Data

For each MCE, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2022–2023. 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, timeliness, or accessibility of care and services for each health plan independently as well as related to statewide improvement.

3. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Statewide Results

Table 3-1 shows the FY 2022–2023 statewide PIP results for the RAEs and the MCOs.

Table 3-1—FY 2022–2023 Statewide PIP Results

MCE	PIP Topic	Module Status	Validation Status
RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
NHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
COA Region 3	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
HCI	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
COA Region 5	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
CCHA Region 6	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
CCHA Region 7	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
RMHP Prime	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*Moderate Confidence*

Statewide Conclusions and Recommendations Related to Validation of PIPs

During FY 2022–2023, the MCEs continued ongoing PIPs focused on *Depression Screening and Follow-Up After a Positive Depression Screen*. The seven RAEs and two MCOs (MCEs, collectively) completed Module 4—PIP Conclusions, the final module of the rapid-cycle PIP process, during FY 2022–2023. In Module 4, the MCEs reported final PIP results, conclusions, and lessons learned. HSAG reviewed and conducted the final validation of the Module 4 submissions and assigned an overall validation status to each PIP. All RAEs and one MCO, DHMP, received a validation rating of *High Confidence*, based on the validation findings. The remaining MCO, RMHP Prime, received a validation rating of *Moderate Confidence*.

Based on the FY 2022–2023 PIP validation activities, HSAG identified the following statewide strengths:

- The MCEs developed and carried out methodologically sound improvement projects.
- The MCEs accurately reported SMART Aim measure and intervention testing results.
- The MCEs' reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance and/or met the SMART Aim goals for the *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures.
- The MCEs' intervention testing results demonstrated programmatically significant improvement and/or clinically significant improvement in the *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures linked to the tested interventions.

Based on the FY 2022–2023 PIP validation activities, HSAG did not identify any statewide opportunities for improvement.

As the MCEs complete the *Depression Screening and Follow-Up After a Positive Depression Screen* PIPs, HSAG recommends:

- The MCEs apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- The MCEs continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

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 data 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 3-2, RAE-specific and statewide weighted averages are presented for rates validated in FY 2022–2023 for data from FY 2021–2022 (MY 2022). Cells shaded green indicate the performance met or exceeded the FY 2021–2022 (MY 2022) performance goal (as determined by the Department).

Table 3-2—MY 2022 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	53.73%	54.11%	51.53%	53.16%	49.35%	45.37%	61.25%	52.33%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	50.81%	49.78%	46.84%	46.26%	49.38%	58.07%	32.49%	46.98%
Follow-Up Within 7 Days of an ED Visit for SUD	35.88%	28.41%	26.30%	28.84%	30.19%	31.99%	31.97%	30.46%
Follow-Up After a Positive Depression Screen	61.40%	83.84%	46.66%	40.86%	49.02%	52.98%	64.85%	57.09%

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	13.17%	14.57%	14.63%	14.88%	28.93%	18.09%	16.06%	17.05%

Statewide Conclusions and Recommendations

During this measurement period, none of the statewide averages met the performance goal.

HSAG recommends that the RAEs include the results of analyses for the measures listed above and implement the following if the RAE has not already done so:

- Create a dashboard to monitor rates monthly or quarterly.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

HEDIS Measure Rates and Validation—MCOs

Statewide Results

Information Systems Standards Review

HSAG reviewed each MCO's FAR. Each MCO's LO's auditor evaluated the MCO's IS standards and it was determined that all MCOs were fully compliant with all IS standards relevant to the scope of the PMV performed. During review of the IS standards, the auditors identified no notable issues with negative impact on performance measure reporting.

Performance Measure Results

In Table 3-3, MCO-specific and Colorado Medicaid weighted averages are presented for MY 2022. 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.

Table 3-3—MY 2022 Statewide Performance Measure Results for MCOs

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Primary Care Access and Preventive Care			
Breast Cancer Screening			
Ages 52 to 64 Years	46.91%	44.34%	45.65%
Ages 65 to 74 Years	35.82%	41.15%	37.87%
Cervical Cancer Screening			
Cervical Cancer Screening	34.24%	42.38%	37.73%
Child and Adolescent Well-Care Visits			
Total	42.90%	28.73%	42.55%
Childhood Immunization Status			
Combination 3	72.47%	NA	72.47%
Combination 7	59.64%	NA	59.64%
Combination 10	42.05%	NA	42.05%
Chlamydia Screening in Women			
Ages 16 to 20 Years	77.04%	39.34%	76.08%
Ages 21 to 24 Years	70.33%	49.60%	62.14%
Colorectal Cancer Screening			
Ages 46 to 49 Years	14.01%	16.69%	15.09%
Ages 50 to 64 Years	27.05%	36.63%	31.24%
Ages 65 Years and Older	32.99%	36.43%	34.20%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Developmental Screening in the First Three Years of Life			
Total	60.80%	NA	60.78%
Immunizations for Adolescents			
Combination 1 (Meningococcal; Tetanus, Diphtheria, and Pertussis [Tdap])	71.77%	80.00%	71.89%
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	36.84%	26.67%	36.69%
Lead Screening in Children			
Lead Screening in Children	61.16%	NA	61.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	68.09%	23.40%	67.47%
Counseling for Nutrition—Total	73.10%	25.96%	72.44%
Counseling for Physical Activity—Total	71.96%	13.19%	71.14%
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.28%	NA	58.28%
Well-Child Visits From Age 15 Months to 30 Months—Two or More Well-Child Visits	59.29%	NA	59.29%
Maternal and Perinatal Health			
Contraceptive Care—All Women			
Most Or Moderately Effective Method of Contraception (MMEC)—Ages 15 to 20 Years	20.68%	30.09%	21.05%
MMEC—Ages 21 to 44 Years	18.89%	19.57%	19.21%
Long-Acting Reversible Contraception (LARC)—Ages 15 to 20 Years	5.30%	6.94%	5.36%
LARC—Ages 21 to 44 Years	4.95%	4.27%	4.63%
Contraceptive Care—Postpartum Women			
MMEC—3 Days—Ages 15 to 20 Years	25.68%	NA	23.46%
MMEC—3 Days—Ages 21 to 44 Years	27.59%	6.70%	17.51%
MMEC—90 Days—Ages 15 to 20 Years	59.46%	NA	60.49%
MMEC—90 Days—Ages 21 to 44 Years	56.40%	42.16%	49.53%
LARC—3 Days—Ages 15 to 20 Years	6.76%	NA	6.17%
LARC—3 Days—Ages 21 to 44 Years	10.21%	0.49%	5.52%
LARC—90 Days—Ages 15 to 20 Years	27.03%	NA	28.40%
LARC—90 Days—Ages 21 to 44 Years	25.91%	17.16%	21.69%
Prenatal and Postpartum Care			
Postpartum Care	69.45%	36.32%	54.90%
Timeliness of Prenatal Care	77.26%	49.83%	65.21%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Care of Acute and Chronic Conditions			
Asthma Medication Ratio			
Total (Ages 5 to 18 Years)	58.05%	NA	57.14%
Total (Ages 19 to 64 Years)	51.91%	59.06%	55.70%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Ages 3 Months to 17 Years	96.52%	NA	96.52%
Ages 18 to 64 Years	68.26%	48.05%	54.17%
Ages 65 Years and Older	NA	NA	NA
Concurrent Use of Opioids and Benzodiazepines*			
Ages 18 to 64 Years	5.74%	10.26%	8.17%
Ages 65 Years and Older	6.52%	NA	7.74%
Controlling High Blood Pressure			
Ages 18 to 64 Years	47.93%	22.00%	35.12%
Ages 65 to 85 Years	56.64%	23.06%	43.93%
HbA1c Control for Patients With Diabetes			
HbA1c Control (<8.0%)—Ages 18 to 64 Years	44.94%	32.65%	39.73%
HbA1c Control (<8.0%)—Ages 65 to 75 Years	51.44%	40.00%	47.79%
*Poor HbA1c Control (>9.0%)—Ages 18 to 64 Years**	45.15%	61.39%	52.03%
*Poor HbA1c Control (>9.0%)—Ages 65 to 75 Years**	37.77%	52.31%	42.40%
HIV Viral Load Suppression			
Ages 18 to 64 Years	NA	0.00%	0.00%
Ages 65 Years and Older	NA	NA	NA
Use of Opioids at High Dosage in Persons Without Cancer*			
Ages 18 to 64 Years	5.04%	3.36%	4.06%
Ages 65 Years and Older	4.88%	NA	5.07%
Behavioral Health Care			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	47.15%	60.57%	54.29%
Antidepressant Medication Management			
Effective Acute Phase Treatment—Ages 18 to 64 Years	66.37%	62.96%	64.50%
Effective Acute Phase Treatment—Ages 65 Years and Older	76.92%	78.79%	77.65%
Effective Continuation Phase Treatment—Ages 18 to 64 Years	46.53%	43.84%	45.06%
Effective Continuation Phase Treatment—Ages 65 Years and Older	53.85%	42.42%	49.41%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)			
Ages 18 to 64 Years	53.93%	56.28%	55.26%
Ages 65 to 75 Years	NA	NA	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	85.52%	79.22%	81.57%
Follow-Up After Emergency Department Visit for Substance Use			
7-Day Follow-Up—Ages 13 to 17 Years	17.65%	NA	17.65%
7-Day Follow-Up—Ages 18 to 64 Years	20.78%	21.69%	21.04%
7-Day Follow-Up—Ages 65 Years and Older	14.89%	NA	11.67%
30-Day Follow-Up—Ages 13 to 17 Years	23.53%	NA	23.53%
30-Day Follow-Up—Ages 18 to 64 Years	28.33%	36.11%	30.56%
30-Day Follow-Up—Ages 65 Years and Older	21.28%	NA	20.00%
Follow-Up After Emergency Department Visit for Mental Illness			
7-Day Follow-Up—Ages 6 to 17 Years	9.30%	NA	9.20%
7-Day Follow-Up—Ages 18 to 64 Years	16.74%	31.51%	21.34%
7-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA
30-Day Follow-Up—Ages 6 to 17 Years	25.58%	NA	26.44%
30-Day Follow-Up—Ages 18 to 64 Years	24.17%	46.12%	31.01%
30-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Ages 6 to 17 Years	NA	NA	NA
7-Day Follow-Up—Ages 18 to 64 Years	2.47%	33.98%	28.18%
7-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA
30-Day Follow-Up—Ages 6 to 17 Years	NA	NA	NA
30-Day Follow-Up—Ages 18 to 64 Years	17.28%	52.65%	46.14%
30-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	38.89%	NA	40.50%
Continuation and Maintenance Phase	NA	NA	NA
Initiation and Engagement of Substance Use Disorder Treatment			
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	41.59%	33.01%	38.30%
Initiation of SUD Treatment—Total—Ages 65 Years and Older	58.24%	36.49%	51.64%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Engagement of SUD Treatment—Total—Ages 18 to 64 Years	7.07%	13.65%	9.59%
Engagement of SUD Treatment—Total—Ages 65 Years and Older	4.71%	1.35%	3.69%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	NA	NA	58.49%
Cholesterol Testing—Total	NA	NA	43.40%
Blood Glucose and Cholesterol Testing—Total	NA	NA	41.51%
Screening for Depression and Follow-Up Plan			
Ages 12 to 17 Years	34.14%	8.23%	33.62%
Ages 18 to 64 Years	18.40%	7.69%	14.42%
Ages 65 Years and Older	6.26%	2.89%	5.15%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	NA	NA	NA
Use of Pharmacotherapy for Opioid Use Disorder			
Rate 1: Total	51.62%	63.56%	60.90%
Rate 2: Buprenorphine	48.70%	36.44%	39.17%
Rate 3: Oral Naltrexone	1.95%	4.10%	3.62%
Rate 4: Long-Acting, Injectable Naltrexone	1.62%	0.93%	1.09%
Rate 5: Methadone	0.32%	29.17%	22.74%
Use of Services			
Ambulatory Care: Emergency Department Visits*			
Total (Ages 0 to 19 Years)	317.11	502.90	319.68
PQI 01: Diabetes Short-Term Complications Admission Rate*			
Ages 18 to 64 Years	16.69	11.13	14.55
Ages 65 Years and Older	0.00	9.51	3.58
PQI 05: COPD or Asthma in Older Adults Admission Rate*			
Ages 40 to 64 Years	20.13	9.03	15.27
Ages 65 Years and Older	43.95	25.36	36.96
PQI 08: Heart Failure Admission Rate*			
Ages 18 to 64 Years	24.10	5.20	16.02
Ages 65 Years and Older	1,385.48	28.53	236.22
PQI 15: Asthma in Younger Adults Admission Rate*			
Ages 18 to 39 Years	3.50	2.37	3.10
Plan All-Cause Readmissions			
Observed Readmissions	9.54%	7.96%	8.92%
Expected Readmissions	9.49%	9.88%	9.64%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
*Observed-to-Expected (O/E) Ratio**	1.0051	0.8054	0.9247

**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 there was no benchmark for comparison.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statewide Conclusions and Recommendations Related to HEDIS Measure Rates and Validation

The following MY 2022 statewide average 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 2021, or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2021):

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Ages 18 to 64 Years*
- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

The following MY 2022 statewide average 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 2021) for the MCOs:

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years*, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*; and *30-Day Follow-Up—Ages 6 to 17 Years*, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years* and *30-Day Follow-Up—Ages 6 to 17 Years*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

To address these low measure rates, HSAG recommends the MCOs:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the Department consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The Department should encourage the MCOs to consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

Table 3-4 presents the overall percentage of compliance score for each RAE for all standards and the year reviewed.

Table 3-4—Statewide Results for Medicaid RAE Standards

Standard and Applicable Review Years	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	Statewide RAE Average
Standard I—Coverage and Authorization of Services (2022–2023)	**94%^**	**91%v**	**91%^**	**94%v**	**88%^**	**94%^**	**94%^**	**92%^**
Standard II—Adequate Capacity and Availability of Services (2022–2023)	**92%v**	**93%v**	**100%~**	**86%v**	**100%~**	**100%^**	**100%^**	**96%v**
Standard III—Coordination and Continuity of Care (2021–2022)	100%~	100%^	100%~	100%^	100%^	90%v	90%v	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%v	94%~	86%v	94%~	87%^	87%^	89%v
Standard VI—Grievance and Appeal Systems (2022–2023)	**94%^**	**91%^**	**94%^**	**91%^**	**97%^**	**74%^**	**74%~**	**88%^**
Standard VII—Provider Selection and Program Integrity (2020–2021)	94%	94%	100%	94%	100%	100%	100%	97%

Standard and Applicable Review Years	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	Statewide RAE Average
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	94%	100%	94%	100%	100%	100%	98%
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	75%	100%	75%	100%	100%	100%	89%
Standard X—Quality Assessment and Performance Improvement (2020–2021)	100%	100%	100%	100%	100%	100%	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	100%~	86%v	100%^	86%v	100%^	86%^	86%^	92%^
Standard XII—Enrollment and Disenrollment (2022–2023)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Bold text indicates standards that HSAG reviewed during FY 2022–2023.

Green caret (^) indicates an increase from review three years prior. Red caret (v) indicates a decrease from review three years prior.

~ Indicates no change from prior year.

Beginning July 1, 2018, the RAEs began operations. 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 were reviewed for the first time in FY 2020–2021 and no comparison is available. Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023; therefore, no comparison is available.

Table 3-5 presents the compliance scores for record reviews conducted for each RAE during FY 2022–2023.

Table 3-5—Summary of Statewide Average Scores for the FY 2022–2023 RAE Record Reviews

Record Review	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	Statewide RAE Average
Denials (2022–2023)	**96%**	**81%**	**92%**	**92%**	**90%**	**90%**	**95%**	**91%**
Grievances (2022–2023)	**100%**	**98%**	**98%**	**100%**	**100%**	**100%**	**100%**	**99%**
Appeals (2022–2023)	**93%**	**100%**	**100%**	**97%**	**100%**	**85%**	**84%**	**94%**
Credentialing (2020–2021)	100%	100%	100%	100%	100%	100%	100%	100%
Recredentialing (2020–2021)	100%	100%	100%	100%	100%	100%	100%	100%

Bold text indicates record reviews that HSAG conducted during FY 2022–2023.

Table 3-6 presents the overall percentage of compliance score for each MCO for all standards and the year reviewed.

Table 3-6—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 (2022–2023)	**97%~**	**94%^**	**96% ^**
Standard II—Adequate Capacity and Availability of Services (2022–2023)	**92%^**	**92%v**	**92% v**
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%v	89%^	84% ^
Standard VI—Grievance and Appeal Systems (2022–2023)	**80%v**	**94%^**	**87% ^**
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%v	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% ^
Standard XII—Enrollment and Disenrollment (2022–2023)	**100%**	**100%**	**100%**

Bold text indicates standards that HSAG reviewed during FY 2022–2023.

Green caret (^) indicates an increase from review three years prior. Red caret (v) indicates a decrease from review three years prior.

~ Indicates no change from prior year.

Table 3-7 presents the compliance scores for record reviews conducted for each Medicaid MCO during FY 2022–2023.

Table 3-7—Summary of Statewide Average Scores for the FY 2022–2023 MCO Record Reviews

Record Review	DHMP	RMHP Prime	Statewide MCO Average
Denials (2022–2023)	**85%**	**96%**	**91%**
Grievances (2022–2023)	**100%**	**100%**	**100%**
Appeals (2022–2023)	**98%**	**93%**	**96%**
Credentialing (2020–2021)	100%	100%	100%
Recredentialing (2020–2021)	100%	100%	100%

Bold text indicates record reviews that HSAG conducted during FY 2022–2023.

Statewide Conclusions and Recommendations Related to Assessment of Compliance

Based on the four standards reviewed in FY 2022–2023, the Medicaid health plans—both the RAEs and MCOs—demonstrated compliance and strengths in the following:

- All MCEs submitted policies and procedures that outlined comprehensive UM approaches to review and authorize covered services using the Department's definition of "medical necessity" and other nationally recognized review criteria.
- All MCEs met the requirement to conduct IRR testing to ensure consistent application of review criteria and most met IRR testing goals.
- Network adequacy plans, policies, procedures, and committee meeting minutes described oversight and monitoring of the provider network.
- Each MCE submitted policies, procedures, quarterly and annual reporting, as well as provider-facing information to demonstrate oversight of the provider network and range of covered services offered to members. Most included accurate information regarding time and distance standards and timely appointment standards.
- The MCEs informed their provider networks about timely appointment expectations and monitored providers to some extent, including procedures to enlist corrective action plans (CAPs) as necessary.
- The MCEs demonstrated adequate systems to document grievances and appeals, including robust processes to ensure appeals and grievances were accepted orally or in writing. All MCEs conducted staff trainings at the time of onboarding; most held refresher trainings annually, and some described monthly and ad hoc trainings.

- Staff members discussed monitoring grievance and appeal systems and procedures through methods such as monthly audits and documentation reviews.
- Member communications regarding NABDs, grievances, and appeals were written at or around the sixth-grade reading level.
- All MCEs submitted policies and procedures that outlined how members received reasonable assistance such as completing forms, offering accommodations, and other services upon request.
- Staff members described a thorough overview of how the enrollment process begins when the Electronic Data Interchange (EDI) 834 files are received from the Department and are added to their systems with no restriction.

For Medicaid health plans statewide, HSAG identified the following most common opportunities for improvement:

- Most MCEs used shortened time frames in which providers were allowed to submit additional documentation or have a peer-to-peer review, in some cases as short as an hour (for expedited requests) and in other cases 24 hours (in standard requests).
- Many denial records reviewed had timeliness issues regarding the denial decision and/or notification time frame and inaccurate or missing content within the NABD.
- All RAEs reported gaps in SUD access to care, particularly notable gaps in 3.3 and 3.7 withdrawal management (WM). In addition, many RAEs reported gaps related to accessing psychiatric hospitals and psychiatric units in acute care hospitals in rural and frontier counties.
- Both MCOs had inaccurate timeliness content for urgent care services.
- Most MCEs have the opportunity to use extensions for authorization, grievance, and appeal decisions, when in the best interest of the member. Some used shortened time frames in which members or providers were allowed to submit additional documentation.
- Language in either member letters, policies, procedures, websites, or other supporting documentation often incorrectly stated the member needed to follow up an oral appeal request in writing, which is no longer a federal requirement.

To address the opportunities for improvement, HSAG recommends the following:

- Encourage the MCEs to consider using the full review time frame whenever needed and extensions, when appropriate, for authorizations, grievances, and appeal decisions.
- Require the MCEs with findings to enhance procedures and monitoring efforts to ensure that denial notices were sent to the member timely.

- The MCEs should continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM) and access to psychiatric hospitals and psychiatric units in acute care hospitals.
- When updating access to care standards, the Department may consider requiring the MCEs to promptly revise language related to correct standards for timely access to care associated with urgent services in handbooks, policies, or other applicable materials.
- In response to updates to federal requirements, the Department may consider requiring the MCEs to promptly update supporting documentation, for example, when appeals were no longer required in writing.

Validation of Network Adequacy

Time and Distance Analysis

Statewide Results

Quarterly during FY 2022–2023, 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 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 2022–2023 Q2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2022, through December 31, 2022.

For an MCE to be compliant with the FY 2022–2023 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) unless otherwise specified (i.e., 90 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, a minimum of 90 percent of members in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two general BH practitioners as is indicated by the applicable network category minimum time and distance requirements. 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 alternative methods of ensuring access to care for its enrolled members, regardless of a member's county of residence (e.g., the use of telehealth).

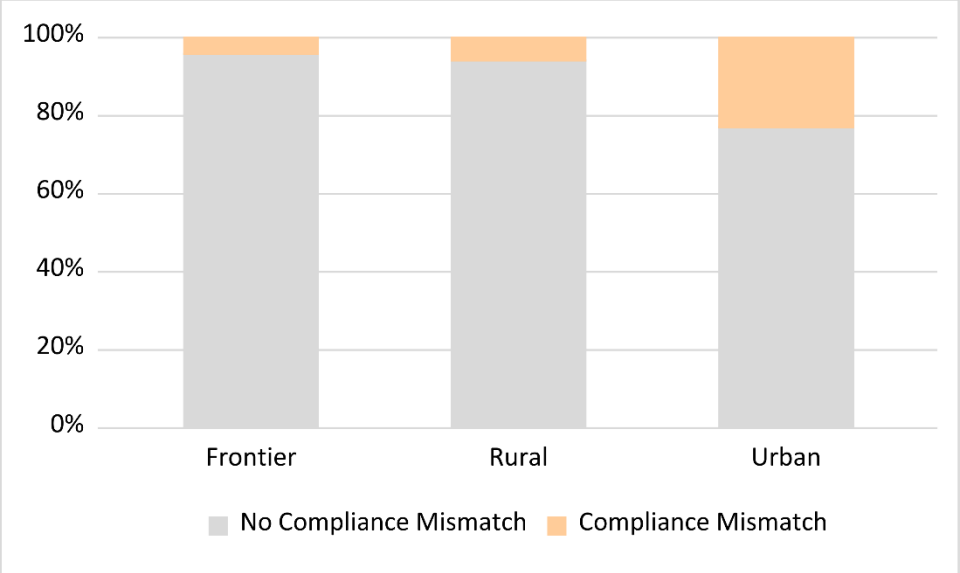
RAE Results

This section summarizes the FY 2022–2023 NAV findings specific to the seven RAEs.

Compliance Match

Figure 3-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the RAEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the RAEs' quarterly geoaccess compliance results) among all RAEs by urbanicity.

Figure 3-1—Aggregate RAE Geoaccess Compliance Validation Results for FY 2022–2023 Q2 by Urbanicity

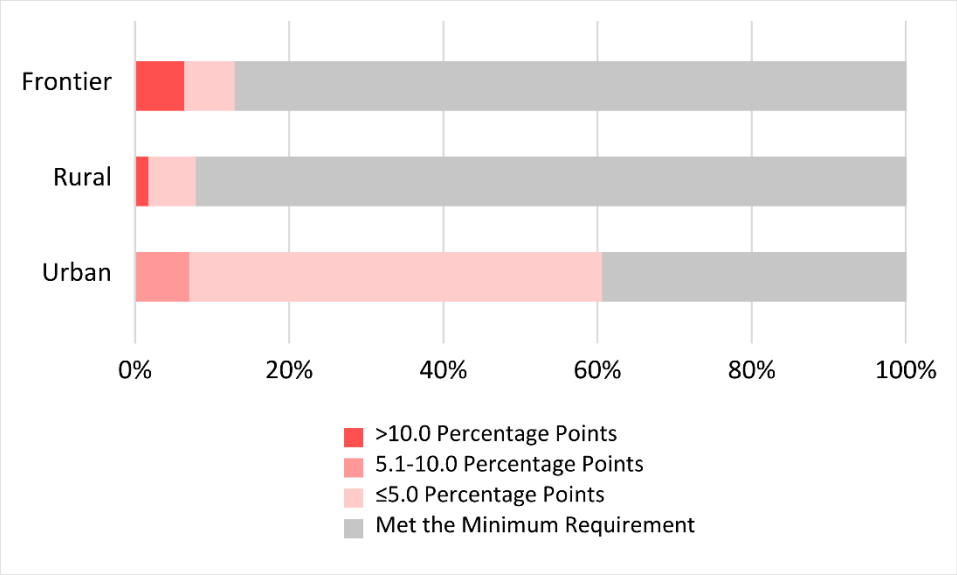


As shown in Figure 3-1, HSAG agreed with 95.9 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 94.2 percent of reported results for rural counties, and 77.0 percent of reported results for urban counties. HSAG disagreed with 4.1 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 5.8 percent of reported results for rural counties, and 23.0 percent of reported results for urban counties.

Access Level Assessment

Figure 3-2 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 RAE members with access in the minimum network requirements by urbanicity for FY 2022–2023 Q2.

Figure 3-2—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, 2022



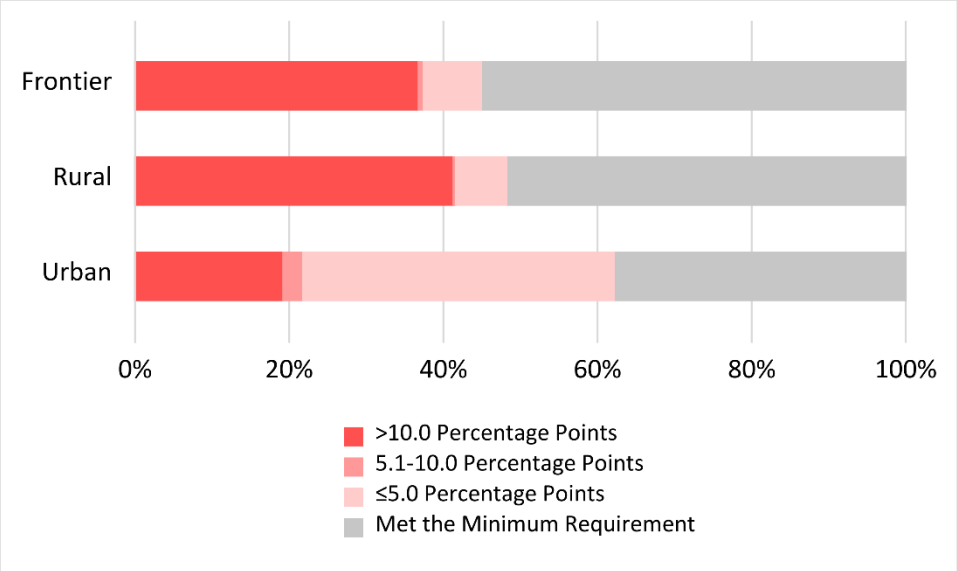
- The first bar in Figure 3-2 reflects a total of 138 PH primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined RAEs are contracted to serve. Of those 138 RAE frontier results, 87.0 percent (n=120) 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 6.5 percent (n=9) of the frontier county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 6.5 percent (n=9) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The second bar in Figure 3-2 reflects a total of 162 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 162 RAE rural results, 92.0 percent (n=149) have 100 percent of RAE members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 6.2 percent (n=10) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 1.9 percent (n=3) of the rural county

results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

- The third bar in Figure 3-2 reflects a total of 84 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 84 RAE urban results, 39.3 percent (n=33) have 100 percent of RAE members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level), 53.6 percent (n=45) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level), and 7.1 percent (n=6) of the urban county results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level).

Figure 3-3 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 2022–2023 Q2.

Figure 3-3—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, 2022



- The top bar in Figure 3-3 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, 54.8 percent (n=164) 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 7.7 percent (n=23) of the RAE and DHMP frontier county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 0.7 percent (n=2) of the frontier county results were within 5.1 to 10.0 percentage points of the minimum network

requirements (i.e., 94.9 to 90 percent access level). In addition, 36.8 percent (n=110) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

- The middle bar in Figure 3-3 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, 51.6 percent (n=181) have 100 percent of RAE members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level), 6.8 percent (n=24) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level), 0.3 percent (n=1) of the rural county results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level), and 41.3 percent (n=145) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The bottom bar in Figure 3-3 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, 37.6 percent (n=88) have 100 percent of RAE members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level), 40.6 percent (n=95) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level), 2.6 percent (n=6) of the urban county results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level), and 19.2 percent (n=45) of the urban county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

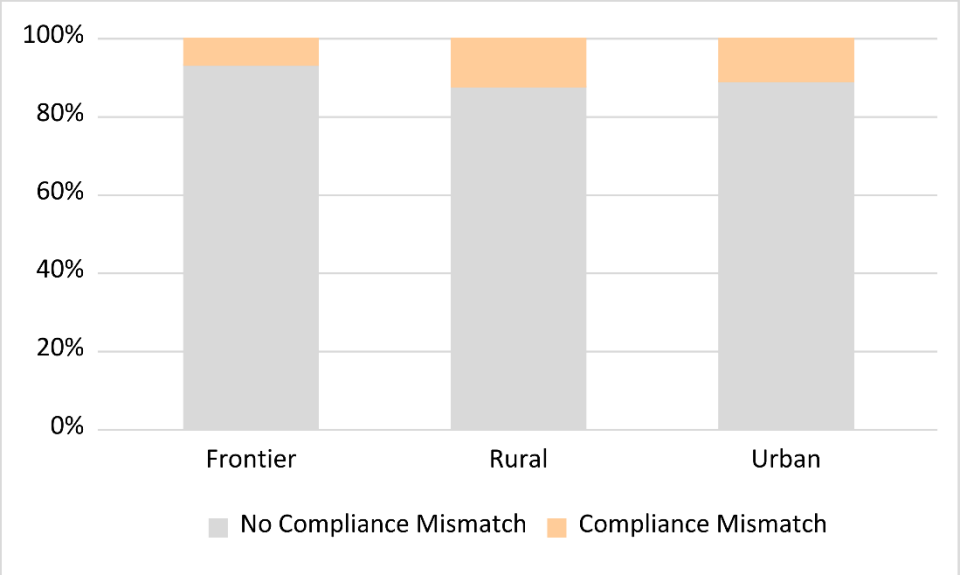
Medicaid MCO Results

This section summarizes the FY 2022–2023 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 services to its members, similar to the RAEs' contractual requirements.

Compliance Match

Figure 3-4 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 3-4—Aggregate MCO Geoaccess Compliance Validation Results for FY 2022–2023 Q2 by Urbanicity

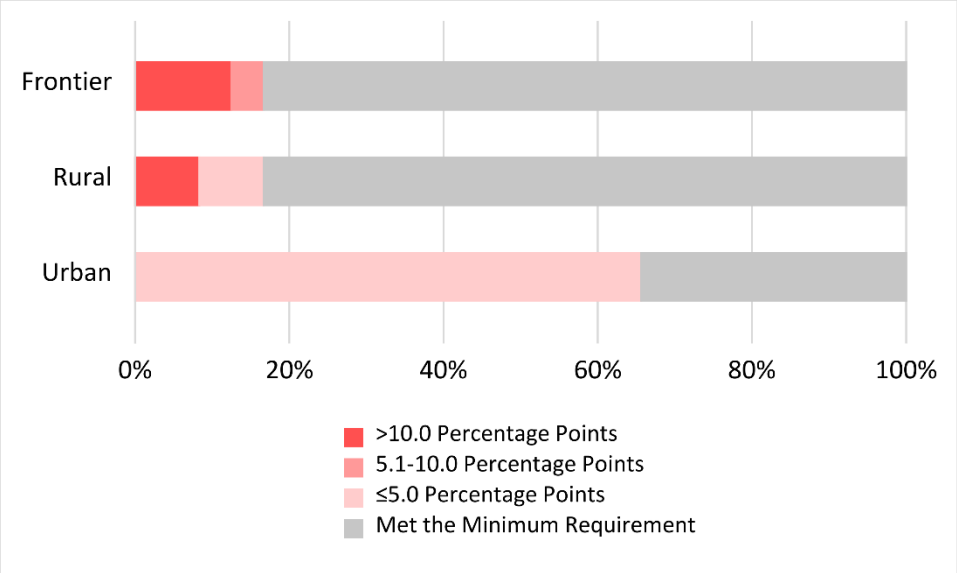


As shown in Figure 3-4, HSAG agreed with 93.3 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 87.8 percent of reported results for rural counties, and 89.2 percent of reported results for urban counties. HSAG disagreed with 6.7 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 12.2 percent of reported results for rural counties, and 10.8 percent of reported results for urban counties.

Access Level Assessment

Figure 3-5 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 Medicaid MCO members by urbanicity for FY 2022–2023 Q2.

Figure 3-5—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, 2022



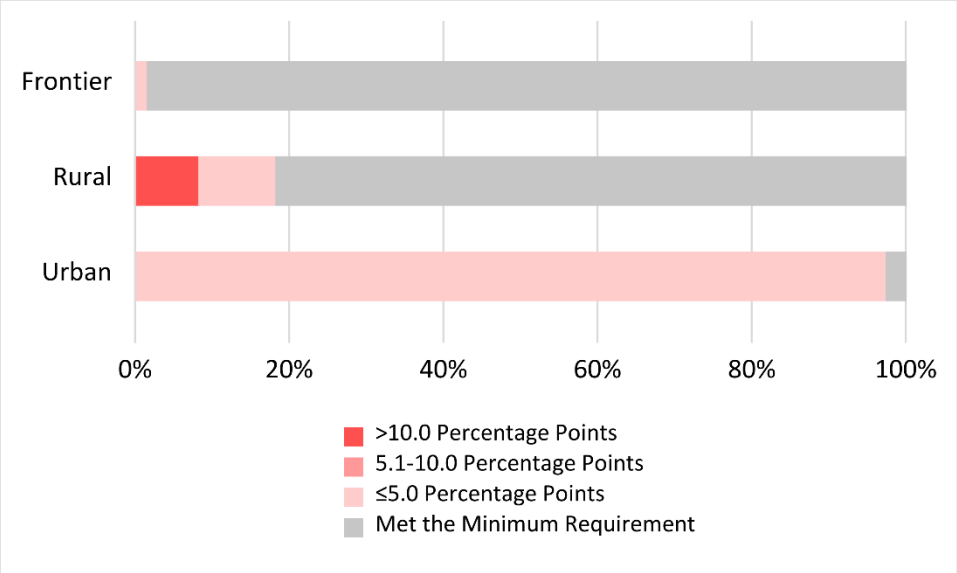
- The top bar in Figure 3-5 reflects a total of 24 PH primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined Medicaid MCOs are contracted to serve. Of those 24 Medicaid MCO frontier results, 83.3 percent (n=20) 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 4.2 percent (n=1) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level) and 12.5 percent (n=3) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The middle bar in Figure 3-5 reflects a total of 48 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 48 Medicaid MCO rural results, 83.3 percent (n=40) have 100 percent of Medicaid MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 8.3 percent (n=4) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 8.3

percent (n=4) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

- The bottom bar in Figure 3-5 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, 34.4 percent (n=11) have 100 percent of Medicaid MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 65.6 percent (n=21) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level).

Figure 3-6 displays the percentage of PH specialist results 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 requirements by urbanicity for FY 2022–2023 Q2.

Figure 3-6—Percentage of Aggregate MCO PH Specialist Results Within the Time and Distance Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



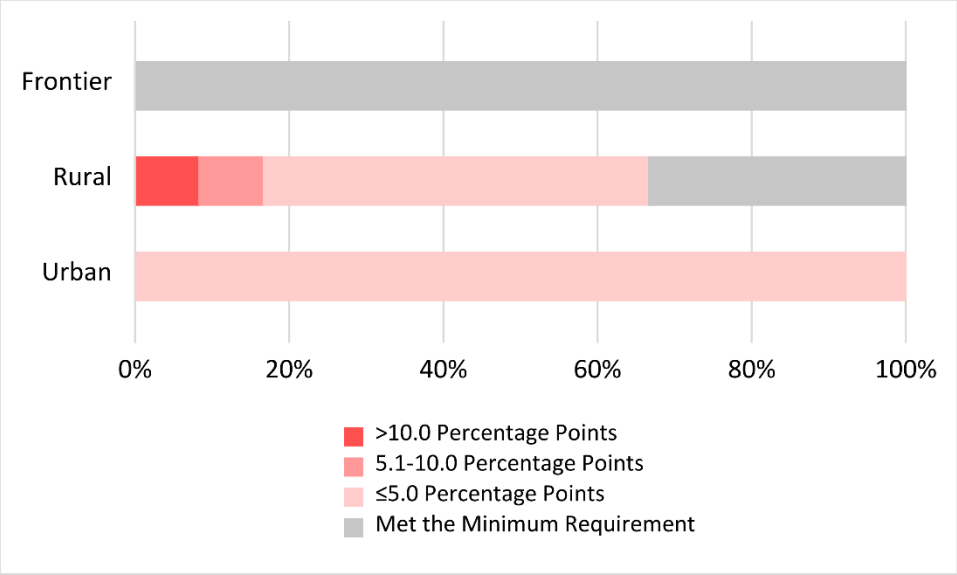
- The top bar in Figure 3-6 reflects a total of 60 PH specialist results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined Medicaid MCOs are contracted to serve. Of those 60 Medicaid MCO frontier results, 98.3 percent (n=59) 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 1.7 percent (n=1) of the frontier county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level).
- The middle bar in Figure 3-6 reflects a total of 120 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 120 Medicaid MCO rural results, 81.7 percent (n=98) have 100 percent of Medicaid MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 10.0 percent (n=12) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 8.3 percent (n=10) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

- The bottom bar in Figure 3-6 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 urban results, 2.5 percent (n=2) have 100 percent of Medicaid MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 97.5 percent (n=78) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level).

Figure 3-7 displays the percentage of PH entity results 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 requirements by urbanicity for FY 2022–2023 Q2.

Figure 3-7—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, 2022



- The top bar in Figure 3-7 reflects a total of six 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 six Medicaid MCO frontier results, 100 percent (n=6) 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 3-7 reflects a total of 12 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 12 Medicaid MCO rural results, 33.3 percent (n=4) have 100 percent of Medicaid MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 50.0 percent (n=6) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 8.3 percent (n=1) of the rural county results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 8.3 percent (n=1) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The bottom bar in Figure 3-7 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 urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level).

Provider Directory Validation

Statewide Results

Table 3-8 summarizes the number of sampled providers and provider locations (i.e., "cases") that were located in the MCEs' online provider directories.

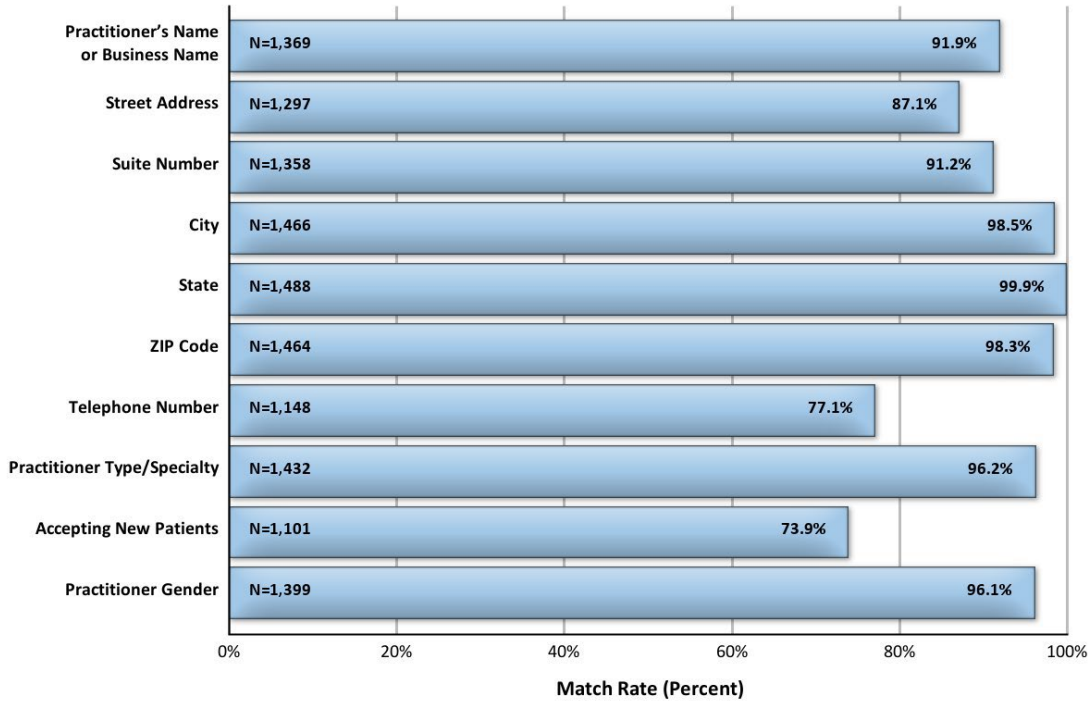
Table 3-8—Summary of Sampled Providers Located in Online Provider Directories

MCE	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	%	Count	%	Count	%
RAEs							
RMHP (RAE 1)	411	56	13.6%	13	3.2%	342	83.2%
NHP (RAE 2)	411	255	62.0%	52	12.7%	104	25.3%
COA (RAE 3)	411	213	51.8%	36	8.8%	162	39.4%
HCI (RAE 4)	411	41	10.0%	154	37.5%	216	52.6%
COA (RAE 5)	411	168	40.9%	51	12.4%	192	46.7%
CCHA (RAE 6)	411	17	4.1%	134	32.6%	260	63.3%
CCHA (RAE 7)	411	66	16.1%	132	32.1%	213	51.8%
RAE Total	**2,877**	**816**	**28.4%**	**572**	**19.9%**	**1,489**	**51.8%**

MCE	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	%	Count	%	Count	%
Medicaid MCOs							
DHMP	411	224	54.5%	50	12.2%	137	33.3%
RMHP Prime	411	100	24.3%	17	4.1%	294	71.5%
Medicaid MCO Total	**822**	**324**	**39.4%**	**67**	**8.2%**	**431**	**52.4%**

Figure 3-8 displays the percentage of sampled provider locations found in the online provider directories that matched between the RAEs' provider data files and the online provider directory information for all study indicators.

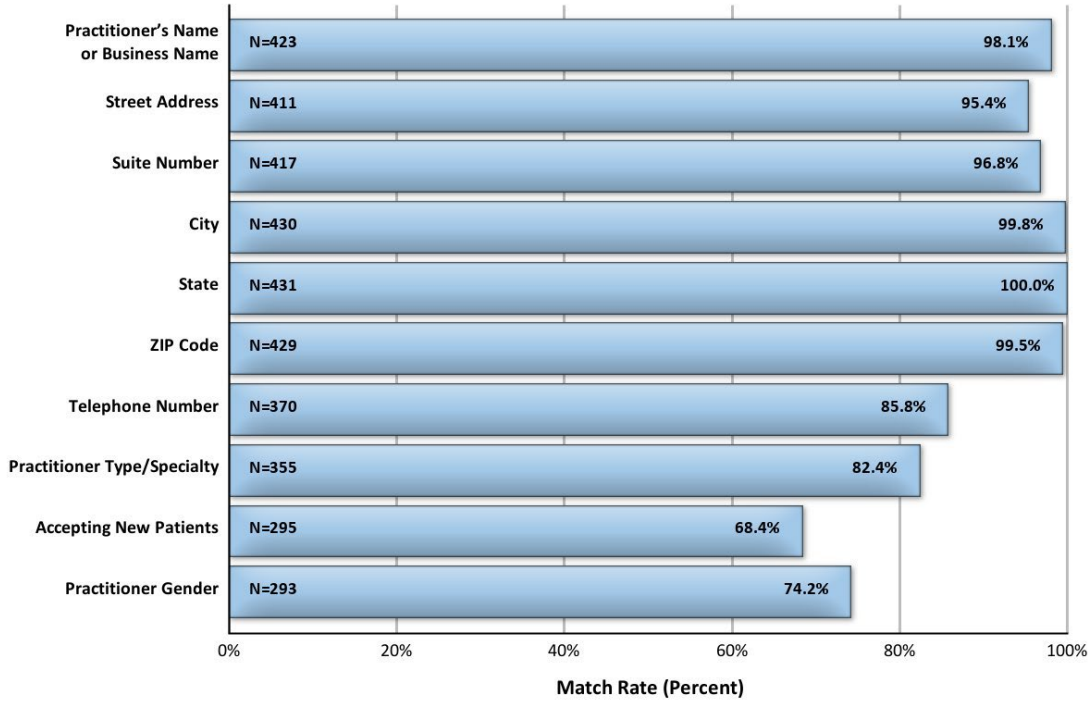
Figure 3-8—RAE Aggregate: PDV Findings[3-1,3-2]



3-1 Indicators missing in the online provider directory may have contributed to low match rates.
3-2 The "Practitioner Gender" indicator was not assessed for facilities.

Figure 3-9 displays the percentage of sampled provider locations found in the online provider directories that matched between the Medicaid MCOs' provider data files and the online provider directory information for all study indicators.

Figure 3-9—Medicaid MCO Aggregate: PDV Findings[3-3,3-4]



Analytic Considerations

Various factors associated with the SFY 2023 PDV may have affected the validity or interpretation of the results when generalizing directory review findings to the MCEs' provider data, including, but not limited to, the following analytic considerations:

- HSAG received the provider data from the MCEs in October 2022 and completed the directory reviews from November 21, 2022, through December 22, 2022. In this time period, it is possible that the provider data submitted by the MCEs could have changed and subsequently been updated in the online provider directories. This limitation would most likely affect the ability to locate the provider in the online directory and exact-match rates for indicators with the potential for short-term changes (e.g., the provider's address, telephone number, or new patient acceptance status). For example, it is possible that a provider was accepting new patients when the MCE submitted the provider data to

[3-3] Indicators missing in the online provider directory may have contributed to low match rates.
[3-4] The "Practitioner Gender" indicator was not assessed for facilities.

HSAG but was no longer accepting new patients when HSAG compared the data to the MCE's online directory. This would result in a lower exact-match rate for this indicator.

- The directory reviews involved a comparison of the data submitted by the MCEs against the information in each MCE's online provider directory.
  - Although provider data may match between both sources for a PDV case, it was beyond the scope of study to evaluate the accuracy of the MCEs' provider data against an external standard (e.g., using telephone survey calls to verify the accuracy of telephone numbers). For example, the address for a provider might match between both sources, but the provider may no longer practice at the specified location.
  - Non-matched provider data do not necessarily indicate that the MCE's online provider directory data are inaccurate. The low number of cases with matching new patient acceptance offers an example, as the provider data submitted to HSAG could not be confirmed since the field was not present (i.e., missing) in some online directories.
- HSAG's reviewers conducted the directory reviews using desktop computers with high-speed internet connections. Reviewers did not attempt to access or navigate the MCEs' online provider directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight).

Statewide Conclusions and Recommendations Related to Network Adequacy

Table 3-9 displays the rate of compliance matches (i.e., HSAG agreed with the MCE's quarterly geoaccess compliance results), by MCE type and urbanicity. For example, HSAG agreed with 93.3 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties.

Table 3-9—Aggregate Percentage of Geoaccess Compliance Matches for FY 2022–2023 Q2 by MCE Type and Urbanicity

MCE 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	93.3%	87.8%	89.2%
RAE	95.9%	94.2%	77.0%

Based on the FY 2022–2023 time and distance and PDV activities, HSAG identified the following strengths:

- The Department built upon the significant growth in its oversight of the RAEs' networks in the prior fiscal year through the use of standardized quarterly reporting materials and implemented standard changes in select BH network categories.

- The MCEs exhibited improvements in member access from the previous fiscal year. Across MCE types, urbanicities, and practitioner network categories, there were notable improvements in the percentage of network requirements assessed for which the MCEs were meeting the Department's 100 percent standard, particularly in the PH primary care provider categories. Improvements among the PH primary care, PH specialist, and BH provider categories were accompanied by relative stability in the accessibility of other provider categories across the MCEs.
- Within the PH specialist provider category, the Medicaid MCOs exhibited marked increases in the percentage of network requirements with 100 percent of members meeting the standards. Among Medicaid MCOs, HSAG noted a slight increase in PH specialist requirements meeting the 100 percent standard in frontier counties, from 97.5 percent to 98.3 percent.
- The RAEs exhibited substantial increases in the percentage of requirements with 100 percent access for the PH primary care provider categories. In frontier counties, the percentage of requirements with 100 percent access increased 18.5 percentage points from 68.5 percent to 87.0 percent, while for rural counties, the increase was 20.7 percentage points from 71.3 percent to 92.0 percent.
- Once located in the directory, RAE providers had match rates above 90 percent for seven of the 10 indicators, and Medicaid MCO providers had match rates above 90 percent for six of the 10 indicators.

Based on the FY 2022–2023 time and distance and PDV activities, HSAG identified the following opportunities for improvement:

- To further assess network adequacy, the Department should consider integrating specified data review topics into network adequacy analysis and an expansion of the NAV dashboard to reflect specific initiatives and goals.
- Although select BH provider category standards lowered from 100 percent to 90 percent of members within the minimum network requirement during FY 2022–2023, the RAEs reported experiencing additional changes to their networks during the Q2 reporting period such as implementation of new data systems, reclassifications of practitioners, and various internal consolidation efforts.
- Only 51.8 percent of the RAE providers and 52.4 percent of the Medicaid MCO providers were located in the online provider directory at the sampled location.
- The street address, telephone number, and accepting new patients indicators had match rates below 90 percent for the RAE providers.
- The telephone number, practitioner type/specialty, accepting new patients, and practitioner gender indicators had match rates below 90 percent for the Medicaid MCO providers.

To address these opportunities for improvement, HSAG identified the following promising practices and recommendations:

- The Department may consider the extent to which the MCEs offer alternative 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 (e.g., telehealth).
- The Department may consider continuing the development and implementation of formal network exception policy and request templates to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards.
- The Department may 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.
- Since the MCEs supplied HSAG with the provider data used for the directory reviews, the Department may want to consider supplying each MCE with case-level data files containing mismatched information between the MCE's data and the MCE's online provider directory and require the MCEs to address these deficiencies.
- The MCEs should test their internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, each MCE should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the MCEs' data that could not be located in the online provider directory.

Encounter Data Validation—RAE 411 Over-Read

Statewide Results

Table 3-10 presents the RAEs' aggregated (which includes DHMP's 411 results) self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-10—FY 2022–2023 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	88.2%	97.3%
Diagnosis Code	94.2%	91.7%	95.7%
Place of Service	NA	83.4%	95.7%
Service Category Modifier	NA	89.1%	97.3%
Units	NA	94.2%	97.4%
Revenue Code	98.7%	NA	NA
Discharge Status	89.7%	NA	NA
Service Start Date	97.7%	94.8%	98.0%
Service End Date	98.5%	94.7%	97.9%
Population	NA	94.8%	98.2%
Duration	NA	91.9%	97.4%
Staff Requirement	NA	92.2%	98.2%

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

Table 3-11 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 3-11—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%	100%
Diagnosis Code	95.0%	100%	98.8%
Place of Service	NA	92.5%	100%
Service Category Modifier	NA	88.8%	85.0%
Units	NA	100%	100%

Data Element	Inpatient Services (80 Over-Read Cases)	Psychotherapy Services (80 Over-Read Cases)	Residential Services (80 Over-Read Cases)
Revenue Code	100%	NA	NA
Discharge Status	96.3%	NA	NA
Service Start Date	98.8%	100%	100%
Service End Date	95.0%	100%	100%
Population	NA	100%	100%
Duration	NA	100%	100%
Staff Requirement	NA	98.8%	100%

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 2022–2023 is the fourth year in which the RAEs and DHMP have used MRR to validate BH encounter data under the Department's guidance, and the EDV results allow the RAEs, DHMP, and the Department to monitor QI within the RAEs' and DHMP's 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.

Based on the FY 2022–2023 EDV and over-read activities for the RAEs and DHMP, HSAG identified the following strengths:

- Across all service categories, the HSAG over-read results were high, with a 100 percent agreement rate for one of the five validated data elements for inpatient services cases, six of the 10 validated data elements for psychotherapy services, and eight of the 10 validated data elements for residential services. For those data elements where HSAG did not agree with the RAEs' and DHMP's reviewers 100 percent of the time, HSAG agreed with the reviewers greater than 90.0 percent of the time for all data elements, except for *Service Category Modifier* for both psychotherapy services and residential services cases.

Based on the FY 2022–2023 EDV and over-read activities for the RAEs and DHMP, HSAG identified the following opportunities for improvement:

- Across the psychotherapy services and residential services categories, the S*ervice Category Modifier* data element had the lowest agreement rate between the RAEs' and DHMP's reviewers and HSAG's reviewers with agreement rates of 88.8 percent and 85.0 percent, respectively. For all instances, the RAEs' and DHMP's reviewers indicated that the medical record did not support the encounter data, whereas HSAG's reviewers indicated that the medical record did support the encounter data.

To address these opportunities for improvement, HSAG recommends:

- Based on the EDV and over-read results described in this report, the Department collaborate with the RAEs, DHMP, and HSAG to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of the RAEs' and DHMP's provider training and/or corrective action documentation, reviewing the RAEs' and DHMP's policies and procedures for monitoring providers' BH encounter data submissions, and verifying that the RAEs and DHMP are routinely monitoring encounter data quality beyond the annual RAE 411 EDV.

Encounter Data Validation—MCO 412 Over-Read

Statewide Results

Table 3-12 presents the MCOs' self-reported encounter data service coding accuracy results, aggregated for both MCOs by service category and validated data element.

Table 3-12—FY 2022–2023 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%	93.7%	86.9%	99.5%	93.9%
Through Date	97.1%	NA	NA	NA	97.1%
Diagnosis Code	92.2%	88.8%	77.2%	89.8%	87.0%
Surgical Procedure Code	96.6%	NA	NA	NA	96.6%
Procedure Code	NA	88.8%	82.0%	89.8%	86.9%
Procedure Code Modifier	NA	92.7%	85.9%	98.5%	92.4%
Discharge Status	93.7%	NA	NA	NA	93.7%
Units	NA	92.2%	88.8%	99.5%	93.5%

** 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 3-13 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 3-13—FY 2022–2023 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	98.8%
Outpatient	40	85.0%	200	97.0%
Professional	40	87.5%	200	97.0%
FQHC	40	95.0%	200	99.0%
Total	160	90.6%	840	98.0%

Overall, results from HSAG's FY 2022–2023 MCO 412 EDV over-read showed that 145 out of 160 cases had complete case-level agreement with the MCOs' internal validation, resulting in a 90.6 percent complete case-level agreement. Additionally, HSAG agreed with 98.0 percent of the MCOs' internal validation results for the total number of individual data elements reviewed.

Statewide Conclusions and Recommendations Related to MCO 412 Over-Read

Based on the FY 2022–2023 EDV and over-read activities for the Medicaid MCOs, HSAG identified the following strengths:

- 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.

Based on the FY 2022–2023 EDV and over-read activities for the Medicaid MCOs, HSAG identified the following opportunities for improvement:

- Among both MCOs, the self-reported service coding accuracy results indicated that the *Diagnosis Code* data element for professional encounters had the lowest percentage of support among all the data elements, with a rate of 77.7 percent for DHMP and a rate of 76.7 percent for RMHP Prime.
- RMHP Prime noted in its encounter data quality report that it was unable to procure medical records for 16 out of the 412 sampled cases. None of the unprocured records were part of the over-sample; however, a high volume of unprocured records may affect the validity of the service coding accuracy report.

To address 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—RAEs

Statewide Results

Adult Survey

Table 3-14 shows the adult CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2022–2023.

Table 3-14—FY 2022–2023 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	55.6%	57.8%	54.9%	52.9%	56.3%	50.1%	52.6%	53.8%
Rating of All Health Care	48.8%	45.6%+	47.4%	46.2%	49.1%	48.8%	52.4%+	48.5%
Rating of Personal Doctor	63.8%	68.0%+	62.7%	61.5%	64.4%	57.6%	62.1%	62.2%
Rating of Specialist Seen Most Often	64.6%+	62.9%+	63.7%+	61.6%+	71.1%+	58.3%+	68.8%+	64.2%
Getting Needed Care	78.8%	84.7%+	72.3%+	80.3%	78.0%	80.0%+	81.6%+	78.3%
Getting Care Quickly	80.0%+	80.5%+	72.6%+	80.2%+	80.5%+	83.2%+	81.7%+	78.9%
How Well Doctors Communicate	96.7%+	91.5%+	90.3%+	93.9%	93.7%	91.2%+	93.5%+	92.7%
Customer Service	82.4%+	94.2%+ ↑	82.0%+	95.1%+ ↑	87.7%+	86.5%+	82.9%+	85.9%

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 2022–2023 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the Colorado RAE aggregate.*

Child Survey

Table 3-15 shows the child CAHPS results for the seven RAEs and the Colorado RAE aggregate (i.e., statewide average) for FY 2022–2023.

Table 3-15—FY 2022–2023 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	71.7%	70.2%	66.8%	68.9%	74.0% ↑	65.5%	58.4% ↓	67.2%
Rating of All Health Care	68.2%	68.0%	67.1%	67.7%	69.8%	68.7%	54.8%	65.6%
Rating of Personal Doctor	72.1%	71.4%	71.9%	66.6% ↓	82.3% ↑	77.7%	69.6%	72.8%
Rating of Specialist Seen Most Often	67.5%+	75.2%+	62.1%+	82.0%+	84.9%+	76.0%+	72.8%+	71.4%
Getting Needed Care	82.7%	89.7%+ ↑	76.4%	84.3%+	81.0%	86.6%	73.9%+ ↓	80.4%
Getting Care Quickly	88.9%	91.0%+ ↑	84.6%	87.8%+	81.2%	87.0%	78.5%+ ↓	85.0%
How Well Doctors Communicate	95.5%	95.4%	93.2%	95.9%	96.5%	93.5%	89.5%	93.7%
Customer Service	86.8%+	95.9%+	88.8%+	92.4%+	88.8%+	82.0%+	84.4%+	87.7%

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 2022–2023 score is statistically significantly higher than the Colorado RAE aggregate.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the Colorado RAE aggregate.*

Statewide Conclusions and Recommendations Related to RAE CAHPS

Adult Survey

The following RAEs' FY 2022–2023 CAHPS scores were statistically significantly higher than the Colorado RAE aggregate scores:

- NHP and HCI (*Customer Service*)

The following RAEs' FY 2022–2023 CAHPS scores were lower, although not statistically significantly, than the Colorado RAE aggregate scores:

- RMHP (*Customer Service*)
- NHP (*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*)
- COA Region 3 (*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*)
- HCI (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*)
- COA Region 5 (*Getting Needed Care*)
- CCHA Region 6 (*Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*)
- CCHA Region 7 (*Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service*)

To address these low CAHPS scores, HSAG recommends the Department consider:

- Collaborating with each RAE to develop initiatives designed to improve processes that may impact members' perceptions of the quality, timeliness, and accessibility of their care.
- Determining if any best practices of the RAEs with scores that are higher than the Colorado RAE aggregate can be shared and duplicated with the RAEs with scores that are lower than the Colorado RAE aggregate.

For additional information about the CAHPS activities and results for FY 2022–2023, refer to the Medicaid aggregate CAHPS report on the Department's website.[3-5]

Child Survey

The following RAEs' FY 2022–2023 CAHPS scores were statistically significantly higher than the Colorado RAE aggregate scores:

- NHP (*Getting Needed Care* and *Getting Care Quickly*)
- COA Region 5 (*Rating of Health Plan* and *Rating of Personal Doctor*)

The following RAEs' FY 2022–2023 CAHPS scores were statistically significantly lower than the Colorado RAE aggregate scores:

- HCI (*Rating of Personal Doctor*)
- CCHA Region 7 (*Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly*)

To address these low CAHPS scores, HSAG recommends the Department consider:

- Collaborating with each RAE to develop initiatives designed to improve processes that may impact members' perceptions of the quality, timeliness, and accessibility of their care.
- Determining if any best practices of the RAEs with scores that are statistically significantly higher than the Colorado RAE aggregate can be shared and duplicated with the RAEs with scores that are statistically significantly lower than the Colorado RAE aggregate.

For additional information about the CAHPS activities and results for FY 2022–2023, refer to the Medicaid aggregate CAHPS report on the Department's website.[3-6]

[3-5] Health Services Advisory Group, Inc. 2023 Colorado Adult Regional Accountable Entity (RAE) Member Experience Report, September 2023. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2023_CO%20CAHPS_RAE_Adult_Survey_Report_Final.pdf. Accessed on: Dec 5, 2023.

[3-6] Health Services Advisory Group, Inc. 2023 Colorado Child Regional Accountable Entity (RAE) Member Experience Report, September 2023. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2023_CO%20CAHPS_RAE_Child_Survey_Report_Final.pdf. Accessed on: Dec 5, 2023.

CAHPS Survey—MCOs

Statewide Results

Adult Survey

Table 3-16 shows the adult Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2022–2023.[3-7]

Table 3-16—FY 2022–2023 Adult Medicaid CAHPS Results for MCOs

Measure	FY 2022–2023 DHMP Score	FY 2022–2023 RMHP Prime Score
Rating of Health Plan	58.9%	70.5%
Rating of All Health Care	51.1%	55.3%
Rating of Personal Doctor	68.2%	73.2%
Rating of Specialist Seen Most Often	62.0%	65.4%
Getting Needed Care	72.0%	86.1%
Getting Care Quickly	71.3%	88.7%
How Well Doctors Communicate	91.7%	94.7%
Customer Service	88.9%+	92.3%+

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

Child Survey

Table 3-17 shows the child Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2022–2023.[3-8]

Table 3-17—FY 2022–2023 Child Medicaid CAHPS Results for MCOs

Measure	FY 2022–2023 DHMP Score	FY 2022–2023 RMHP Prime Score
Rating of Health Plan	73.1%	63.1%
Rating of All Health Care	72.4%+	71.0%
Rating of Personal Doctor	84.6%	69.8%

[3-7] HSAG did not combine DHMP's and RMHP Prime's adult 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.

[3-8] HSAG did not combine DHMP's and RMHP Prime's child CAHPS results into a statewide average due to the differences between the health plans' Medicaid populations. Therefore, a statewide average is not presented in the table.

Measure	FY 2022–2023 DHMP Score	FY 2022–2023 RMHP Prime Score
Rating of Specialist Seen Most Often	65.0%+	76.3%+
Getting Needed Care	71.4%+	88.4%+
Getting Care Quickly	78.1%+	91.6%+
How Well Doctors Communicate	94.0%+	97.4%+
Customer Service	88.9%+	82.0%+

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.

Statewide Conclusions and Recommendations Related to MCO CAHPS

Adult Survey

Please refer to Section 4 of this report for the detailed adult MCO CAHPS results.

Child Survey

Please refer to Section 4 of this report for the detailed child MCO CAHPS results.

Quality Improvement Plan

Statewide Results

Table 3-18 presents the FY 2022–2023 RAE 411 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the RAEs and DHMP (MCEs).

Table 3-18—Comparative Average Summary of Accuracy Scores for MCEs

Claim Type	Time/Phase	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	DHMP 411
Inpatient Services	Baseline	79%	NA	84%	NA	85%	77%	58%	85%
	Month 1	100%	NA	100%	NA	100%	100%	100%	100%
	Month 2	94%	NA	100%	NA	50%	100%	100%	100%
	Month 3	95%	NA	100%	NA	100%	100%	100%	100%
Psychotherapy Services	Baseline	62%	68%	82%	85%	80%	88%	84%	81%
	Month 1	84%	100%	85%	100%	100%	100%	100%	83%
	Month 2	92%	100%	80%	100%	100%	100%	100%	83%
	Month 3	73%	100%	90%	100%	100%	100%	100%	83%
Residential Services	Baseline	37%	NA	NA	NA	NA	77%	83%	NA
	Month 1	93%	NA	NA	NA	NA	100%	100%	NA
	Month 2	100%	NA	NA	NA	NA	100%	100%	NA
	Month 3	100%	NA	NA	NA	NA	100%	100%	NA

**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.

Table 3-19 presents the FY 2022–2023 MCO 412 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the MCOs.

Table 3-19—Comparative Average Summary of Accuracy Scores for MCOs

Claim Type	Time/Phase	RMHP Prime	DHMP
Inpatient Services	Baseline	NA	NA
	Month 1	NA	NA
	Month 2	NA	NA
	Month 3	NA	NA
Outpatient Services	Baseline	75%	88%
	Month 1	95%	100%
	Month 2	100%	80%
	Month 3	100%	80%

Claim Type	Time/Phase	RMHP Prime	DHMP
Professional Services	Baseline	56%	78%
	Month 1	0%	83%
	Month 2	0%	80%
	Month 3	0%	90%
FQHC	Baseline	88%	85%
	Month 1	99%	83%
	Month 2	100%	77%
	Month 3	100%	73%

**Green shading indicates accuracy of 90 percent and higher; red shading indicates accuracy less than 90 percent.*

NA indicates the MCO did not have baseline scores under 90 percent; therefore, no comparisons can be made.

Statewide Conclusions and Recommendations Related to the QUIP

Based on the FY 2022–2023 QUIP activities, HSAG identified the following statewide strengths:

- The results indicate that each of the MCEs experienced noteworthy improvement due to the interventions implemented for this QUIP.
- For the 411 QUIP, the residential services claim type had the highest accuracy at 100 percent (although it only included three MCEs), followed by the inpatient services claim type at 99 percent (six MCEs).
- For one 412 MCO, by end of month three, the outpatient and FQHC claim types had the highest accuracy at 100 percent in both months two and three. The other MCO met the 90 percent accuracy threshold by end of month three for the professional services claim type.
- The most common interventions reported by the MCEs participating in both the 411 and 412 QUIPs included improving and implementing education and training to increase compliance; some MCEs used CAPs to initiate these improvements, and a few MCEs worked with providers to update their EHRs to better map encounter data.

Based on the FY 2022–2023 QUIP activities, HSAG identified the following statewide opportunities for improvement:

- The lowest baseline scores from the 411 QUIP were reported for one MCE in the residential services claim type in which accuracy ranged from 30 percent to 39 percent.

- Both the MCOs participating in the 412 QUIP reported struggling to receive medical records from pilot partners.

To address these opportunities for improvement, HSAG recommends:

- The MCEs maintain ongoing oversight of encounter data, and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Mental Health Parity Audit

Statewide Results

Table 3-20 presents the FY 2022–2023 MHP Audit statewide results for the RAEs and MCOs.

Table 3-20—MHP Audit Statewide Results for RAEs and MCOs

MCE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
RAEs—MH/SUD Services					
RMHP Region 1	1	91%	Inpatient	99%	99%∧
			Outpatient	100%	
NHP Region 2	2	98%	Inpatient	93%	91%∨
			Outpatient	86%	
COA Region 3	3	100%	Inpatient	98%	96%∨
			Outpatient	94%	
HCI Region 4	4	94%	Inpatient	93%	92%∨
			Outpatient	89%	
COA Region 5	5	99%	Inpatient	93%	94%∨
			Outpatient	94%	
CCHA Region 6	6	86%	Inpatient	96%	97%∧
			Outpatient	99%	
CCHA Region 7	7	81%	Inpatient	90%	92%∧
			Outpatient	93%	
MCOs—MH/SUD and Medical/Surgical (M/S) Services					
DHMP		97%	Inpatient	98%	97%~
			Outpatient	96%	

MCE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
RMHP Prime		89%	Inpatient	100%	100%∧
			Outpatient	100%	

∨ *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 2022–2023, most (five or more) MCEs—both the RAEs and MCOs—demonstrated the following strengths statewide:

- An increase or consistent compliance scores from the previous review year.
- Used nationally recognized UR criteria such as Milliman Criteria Guidelines (MCG), InterQual UR criteria, or ASAM LOC criteria.
- 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 percent or 90 percent.
- Within policies and procedures, all MCEs described an appropriate level of expertise for medical necessity determinations. All record reviews demonstrated that all MCEs consistently documented the individual who made the ABD. Additionally, the documentation within the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so.
- Most MCEs followed policies and procedures to offer peer-to-peer reviews with the requesting provider before issuing a medical necessity denial determination.
- Consistency between the reason for the denial determination stated within the NABDs sent to members and the reason for the determination that was documented in the UM system.
- Used a Department-approved NABD template, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCE in filing, access to pertinent records, and the reason for the denial. Additionally, most of the MCEs consistently listed all required ASAM dimensions for SUD inpatient and residential denials and how the dimensions were considered when making the denial determination.

For the MCEs statewide, the most common opportunities for improvement were the following:

- Most MCEs were out of compliance for timeliness in notifying the provider of the denial determination and/or sending the NABD to the member within the required time frame, despite accurate policies and procedures.
- While all MCEs articulated (in policy and procedures described during the MHP interviews) the intent to write NABDs in language that is easy to understand for members, most MCEs sent NABDs that included high reading-grade-level scores. The most common findings in the NABDs included: use of medical terminology without plain language explanation to further simplify the NABD for the member, use of acronyms without spelling the acronym out in its entirety the first time it is used within the NABD (e.g., Intentive Outpatient [IOP]), and not stating member-specific information to provide background information to the member (e.g., what symptoms were found to be present or not present), which often caused the NABD to be short, unclear, and/or not member friendly.

To address these opportunities for improvement, HSAG recommends:

- The Department work with the MCEs to develop and implement ongoing staff training and monitoring to ensure adherence to the required time frames.
- The Department encourage the MCEs to implement best practices in completing member-specific information within the NABD template and provide guidance to the MCEs to consistently use the Department-approved template in a way that provides complete and accurate information in a clear and easy-to-understand format and reading grade level.

EPSDT Services Audit

Statewide Results

Table 3-21 presents the MCE overall outcomes from the EPSDT services audit based on three components: desk review, non-utilizer record review, and post-denial record review.

Table 3-21—MCE Scores Related to EPSDT Criteria

MCE	Desk Review Score	Non-Utilizer Record Review Score	Post-Denial Record Review Score	Percentage of Criteria in Evidence
RMHP	100%	88%	85%	90%
NHP	100%	63%	86%	83%
COA Region 3	100%	69%	73%	78%
HCI	100%	63%	63%	71%
COA Region 5	100%	75%	75%	83%
CCHA Region 6	100%	86%	79%	86%
CCHA Region 7	100%	86%	73%	86%
DHMP	100%	63%	75%	77%
MCE Total Average	**100%**	**74%**	**76%**	**82%**

Statewide Conclusions and Recommendations Related to EPSDT Services Audit

HSAG identified the following overarching strengths in the MCEs' procedural documentation:

- All eight MCEs submitted detailed UM policies, procedures, and supporting documentation and operated with a specific EPSDT policy. All MCEs used provider newsletters to educate and remind providers about EPSDT services.
- Four MCEs used best practices related to provider training. For example, RMHP invited an external presenter, NHP hosted trainings within the community, and CCHA Region 6 and CCHA Region 7 recorded a training that was viewed over 300 times. HSAG recommends that, whenever appropriate, the trainings are recorded and distributed across all MCEs.
- RMHP introduced desktop procedures that require staff members to thoroughly document their review of EPSDT medical necessity criteria in addition to the general guidelines, which HSAG recognized as a best practice.

HSAG identified the following overarching strengths in the MCEs' non-utilizer documentation:

- All except four members out of 120 in the sample received at least one annual non-utilizer outreach attempt during the review period. And all but one MCE conducted multiple outreach attempts to non-utilizers during the review period.
- Six out of the eight MCEs used multiple methods of non-utilizer outreach during the review period, and COA Region 5, CCHA Region 6, and CCHA Region 7 demonstrated the most staggered outreach attempts.
- RMHP used a "Sorry We Missed You" letter for non-utilizers that included the EPSDT flyer; HSAG recognized including the EPSDT flyer and follow-up on unsuccessful outreach attempts as a best practice.

HSAG identified the following overarching strengths in the MCEs' denial documentation:

- All MCEs used the Department's NABD template during the review period. All MCEs used nationally recognized UM criteria. HSAG noted that the MCG in particular included specific aspects of EPSDT medical necessity considerations.
- Some of the NABDs included additional specific next steps for the members, such as the alternative LOC recommended and the phone number for the member to request these services. RMHP, NHP, and HCI described authorizing the alternative LOC; although this was not always communicated in the NABD, it was sometimes conveyed in a separate approval letter.
- RMHP's care coordination efforts post denial included outreach attempts and sending a "Sorry We Missed You" letter that included EPSDT information and the EPSDT flyer.
- RMHP, COA Region 3, and COA Region 5 demonstrated consideration to the individual member's needs when reviewing for medical necessity, going above and beyond the UM criteria.
- COA Region 5's denial sample included an extraordinary example of care coordination in which the father of the member was not only offered transportation, but transportation in the form of a flight, so that he could support the member during treatment and still return to work in time. HSAG noted this as a case where COA Region 5 went above and beyond to obtain necessary supports for the member's treatment.

HSAG identified the following opportunities for improvement:

- During initial outreach, some of the MCEs attempted to obtain the initial health risk assessment (HRA) in conjunction with efforts by the Department; however, reported response rates were low, and the MCEs did not have effective procedures to follow-up with the member and conduct additional assessments.
- Most MCEs were not able to provide detailed documentation for the non-utilizer sample regarding initial enrollment outreach due to members being enrolled at the onset of the RAEs in July 2018.

HSAG noted the MCEs experienced difficulty reporting initial enrollment outreach due to the shift of responsibilities from the Healthy Communities contractors to the RAEs in FY 2021.

- Most EPSDT outreach focused on general populations and contained generalized information that was not specific to the member.
- HSAG noted a possible inconsistency between initial enrollment and initial EPSDT outreach expectations, where initial EPSDT outreach is required by EPSDT federal regulations within 60 days; however, 42 CFR §438.208.b(c) allows 90 days to distribute initial enrollment information, potentially causing confusion among the MCEs regarding initial outreach requirements. Furthermore, Health First Colorado conducts initial outreach through the mailing of the enrollment packet and welcome letter.
- HSAG found that the Department's EPSDT trainings were not updated as frequently as the MCE training.
- Two MCEs could benefit from additional documentation by providing additional documentation from UM reviews conducted for each level of review and by capturing any communications with the requesting provider.
- Based on conversations with MCE and Department staff members, HSAG noted an opportunity to clarify report specifications regarding what counts as "successful" for mailing, phone, interactive voice response (IVR), and text outreach.
- The MCEs did not always submit clear and detailed documentation regarding the full EPSDT medical necessity definition being used for denial determinations due to core concepts of medical necessity being included in the InterQual guidelines and/or the MCG, which are often captured in separate systems. HSAG cautions the assumption that medical necessity for EPSDT eligible populations is fully considered through the use of the InterQual and MCG review tools and encourages the addition of more detailed notes regarding specifically how members meet the threshold.

To address these opportunities for improvement, HSAG recommends:

- The Department encourage the MCEs to engage in additional follow-up efforts to obtain HRAs for members who do not complete an HRA with the Department and follow-up assessments to increase member response rates and actionable data. HSAG encourages the Department to explore whether the Health First Colorado enrollment packet and welcome letter are sufficient for initial EPSDT outreach.
- The Department encourage the MCEs to enhance EPSDT outreach for specific subpopulations, such as members with SHCN or those who have used Psychiatric Residential Treatment Facilities and Qualified Residential Treatment Programs, especially members who eloped or exhibited aggression.
- The Department update its trainings more regularly and consider collaborating with the MCEs when updating the trainings.

- Two MCEs could consider developing a policy regarding delineating steps for working with the Department to request EPSDT services that are not covered by the RAE.
- Quarterly Non-Utilizer Outreach Report specifications include any nuances and parameters, such as whether outreach to members conducted by care coordination delegates counts as completed, and the length or content of a voicemail that would be considered successful (as allowed by Health Insurance Portability and Accountability Act of 1996 [HIPAA] and Telephone Consumer Protection Act [TCPA] guidelines).
- The use of an EPSDT checklist as a best practice to ensure EPSDT is considered prior to the denial and as a guide for situations in which it may be appropriate to refer the member to care coordination.

Substance Use Disorder Utilization Management Over-Read

Statewide Results

Table 3-22 shows the number of MCE denials in the sample and the adjusted number of denials in the sample compared to the number of the denials for which the MCE appropriately applied ASAM criteria.

Table 3-22—MCE Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Adjusted Number of Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Followed ASAM Criteria
RMHP Region 1	18	18	18	100%
NHP Region 2	31	26	26	100%
COA Region 3	48	48	48	100%
HCI Region 4	127	119	119	100%
COA Region 5	33	33	33	100%
CCHA Region 6	32	32	32	100%
CCHA Region 7	18	17	17	100%
DHMP	16	16	16	100%
Total	**323**	**309**[1]	**309**	**100%**

[1] Due to 14 samples being not applicable, the total applicable sample is 309.

Based on the documentation provided by the MCEs, HSAG reviewers confirmed that in 100 percent of applicable sample denials, the MCEs followed ASAM criteria.

Table 3-23 displays the number of MCE denials in the sample compared to the number of denials for which HSAG agreed with the MCE decision.

Table 3-23—MCE Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percentage of Agreement
RMHP Region 1	18	18	100%
NHP Region 2	31	26	100%
COA Region 3	48	48	100%
HCI Region 4	127	119	100%
COA Region 5	33	33	100%
CCHA Region 6	32	32	100%
CCHA Region 7	18	17	100%
DHMP	16	16	100%
Total	**323**	**309**[1]	**100%**

[1] Due to 14 samples being not applicable, the total applicable sample is 309.

HSAG reviewers agreed with the denial decisions made by the MCEs for 100 percent of denials.

Statewide Conclusions and Recommendations Related to SUD UM Over-Read

For the 323 total denial cases reviewed, HSAG confirmed that the MCEs followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential LOCs for 100 percent of 309 applicable sample denial cases. HSAG reviewers agreed with the denial decisions made by each MCE for 100 percent of denial cases. Overall, the MCEs demonstrated consistent and appropriate application of ASAM criteria when making service denial decisions for the sample SUD inpatient hospital and residential LOCs. HSAG reviewers confirmed agreement in 100 percent of denial cases.

HSAG identified the following opportunities for improvement:

- ASAM is in the process of creating a 4th edition of its national guidelines; therefore, new standards will be rolled out at the national level that will need to be incorporated into the Colorado Medicaid system.
- The Department should continue working with the MCEs to distribute NABDs to members in a timely manner and include all required content.

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

- Regarding ASAM opportunities:
  - Continue to provide standard training for the MCEs to support the uniform use of national guidelines.
- Regarding NABDs:
  - Work with the MCEs to ensure descriptions of ASAM dimensions used to support denial determinations are included in NABDs.
  - Revise the standard NABD to prompt the MCEs on how to complete all required fields.
  - Require the MCEs to revise written policies to enhance internal and/or delegation monitoring mechanisms to ensure NABDs consistently contain sufficient detail, demonstrate what ASAM criteria were not met for the specific LOC requested, and are provided to members when required.
  - Revise the MCE contracts to require the MCEs to identify what services would be approved when denying requested services for lack of medical necessity.

Colorado's Medicaid Managed Care Quality Strategy

Overview

The Department last assessed the effectiveness of the Quality Strategy in 2021 and makes updates when significant changes occur pursuant to any new regulatory requirements under 42 CFR §438.340. The Department's Quality Strategy review includes an evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. The Department's Quality Strategy is published to the Department's website and states that the Department takes public recommendations into consideration for updating the Quality Strategy. The Department, in alignment with the Governor's healthcare priorities, continues to focus on reducing healthcare costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive PH and BH services for the Medicaid population, and evaluates its effectiveness based on the following defined goals and objectives stated in the 2021 Quality Strategy Evaluation and Effectiveness Review:

- Healthcare Affordability for Coloradans: Reduce the cost of care in Colorado
- Medicaid Cost Control: Ensure the right services for the right people at the right price
- Member Health: Improve member health
- Customer Service: Improve service to members, care providers, and partners

Colorado's Six Strategic Pillars

In addition to the goals and objectives outlined in the Department's Quality Strategy, Figure 1-1 displays the six strategic 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 strategic pillars are reflected in the quality strategy goals selected by the Department and further supported through EQR work performed.

Figure 3-10—Colorado's Six Strategic Pillars

In consideration of the Department's goals and objectives and Colorado's six strategic pillars for performance management, HSAG provides the following recommendations to improve the quality, timeliness, and accessibility of care.

Healthcare Affordability for Coloradans: Reduce the cost of care in Colorado

HSAG recommends the Department:

- Implement proposed universal provider contracts to reduce administrative burden in the public health system, clarify roles for all parties, and encourage value-based payments.
- Continue to encourage preventive services through its monitoring of associated performance measures, EPSDT participation reports, and claims and utilization data.

Medicaid Cost Control: Ensure the right services for the right people at the right price

HSAG recommends the Department:

- Evaluate network adequacy reports in conjunction with claims and utilization data to further assess network gaps and underutilization of services.
- Continue its support of telemedicine by:
  - Providing the MCEs with ongoing updates.
  - Clarifying the appropriate use of telemedicine.
  - Monitoring claims submissions to ensure accurate claims and track utilization trends.
  - Continuing to invest in broadband support for telemedicine opportunities to improve providers' connectivity, allowing providers to benefit from health information technology/health information exchange.
  - Soliciting recommendations directly from the MCEs to target specific providers who could benefit from additional technology supports (e.g., Community Mental Health Centers [CMHCs]; provider groups; and providers who experience barriers accessing admission, discharge, and transfer [ADT] feeds and/or coordinating the transition of care process).
- Consider focused value-based payments (VBPs) and APMs to address network gaps, particularly with SUD providers in rural and frontier counties, further supporting rural and frontier SUD providers with case management and transportation services.

Member Health: Improve member health

HSAG recommends the Department:

- Continue its implementation of CMS Core Set measures and increase its focus on working with the MCEs with low-performing HEDIS or Core Set measure rates.
- Evaluate the impact of the expanded pregnant and parenting member benefits to 12 months after birth.
- Encourage the MCEs to further invest in neighborhood health through community-based partnerships by supporting proven interventions that address social determinants of health (SDOH).
- Evaluate gaps in the availability of specific ASAM LOCs and access to SUD services.
- Support members' health literacy through the ongoing evaluation of Department and MCE critical member materials by ensuring accuracy, completeness, readability level, and timeliness of member communications. Examples of critical member materials include new enrollee welcome information, annual reminders, and special healthcare topics in member newsletters.

Customer Service: Improve service to members, care providers, and partners

HSAG recommends the Department:

- Further define care coordination and care management (CM) standards, referral procedures, and LOC expectations to monitor and measure outcome metrics for members with SHCN.
- Encourage the statewide adoption of additional evidence-based clinical practice guidelines and monitoring through clinical analytics.
- Consider the additional monitoring of member satisfaction across available datasets, such as CAHPS survey data, quarterly grievance reports, QOC reports, and disenrollment trends.
- Evaluate how its expanded efforts to connect children and families to coverage has impacted outcomes with a comparison of historical and present data, and evaluate for ongoing gaps in care or disparities that require additional focus for the pregnant and parenting population.
- Stipulate definitions for "grievances" and "QOC" in its contracts with the MCEs' definitions in order to work toward consistency in the members' experiences regarding the grievance, QOC, and appeals processes.

Summary and Assessment

The Department's Quality Strategy sets goals to improve the quality of healthcare and services furnished to its members by the MCEs. The Department's Quality Strategy includes a mechanism to monitor all federally required elements and evaluate performance of its MCEs by requiring the following:

- 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 MCEs' compliance programs.
- Participation in mandatory EQR activities as well as participation in custom-developed optional EQR activities designed to further specific Department goals and objectives.
- Ongoing assessments of quality and appropriateness of care.

HSAG recognizes the following programs and initiatives as best practices that are aligned with the Department's goals and objectives:

- The removal of premiums, deductibles, and most copays as of July 2023.
- The implementation of QUIPs that continue to assess the accuracy of encounter data.
- The implementation of PIP topics focused on how providers collect SDOH data.

- The development of a Health Equity Plan (HEP)[3-9] 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 focuses on addressing health disparities. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the Medicaid program's efforts on vaccinations, maternity and perinatal health, BH, and prevention, and aligns with CMS' Adult and Child Core Set measures. The Department provides member-level data (i.e., age, county, disability, gender, language, race, and ethnicity) to the MCEs to assist with identification of priority populations for healthcare initiatives. These efforts include ongoing work to close 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 promotion of the Keep Coloradans Covered campaign, which focuses on informing members of their options at the end of the public health emergency (PHE).
- 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's development of robust dashboards that stratify data to provide the current or most updated disparity data and embed a health equity lens in metric deliverables and analytics. The dashboard includes 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 also provides additional data that can be used by the RAEs and MCOs to target interventions to improve performance measure rates. Notably, monitoring the CMS Core Set measures complements many of the Department's existing programs and initiatives, particularly the HEP.
- The use of eConsults to support PCPs and to improve the referral process. eConsults allows asynchronous electronic clinical communications between primary care medical providers (PCMPs) and specialists. These efforts are expected to expand care in the PCP office by improving access while reducing specialist "no-shows."
- The implementation of Prescriber Tool Phase II, also known as the Social Health Info Exchange, which helps prescribe programs or communicate care coordinators' access to health improvement programs (i.e., prenatal care; diabetes supports; or SDOH, such as SNAP and WIC).
- The initiatives noted above and planned for the ACC Phase III and the Alternative Payment Model 2 (APM 2) are strongly aligned with the Department's work related to the Division of Insurance's implementation of HB22-1325, which aims to enhance quality measures and quality reporting in a manner that is member-centered and member-informed as well as better aligned with overall systems to reduce provider administrative burden.

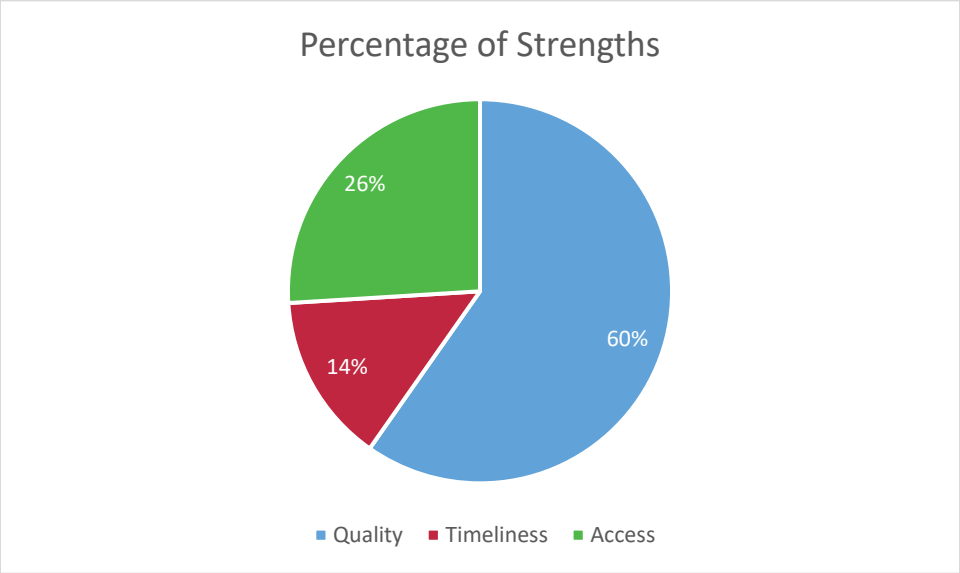
[3-9] Colorado Department of Health Care Policy & Financing. Department Health Equity Plan, Fiscal Year 2022–23. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Health%20Equity%20Plan.pdf. Accessed on: Jan 19, 2024.

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

Regional Accountable Entities

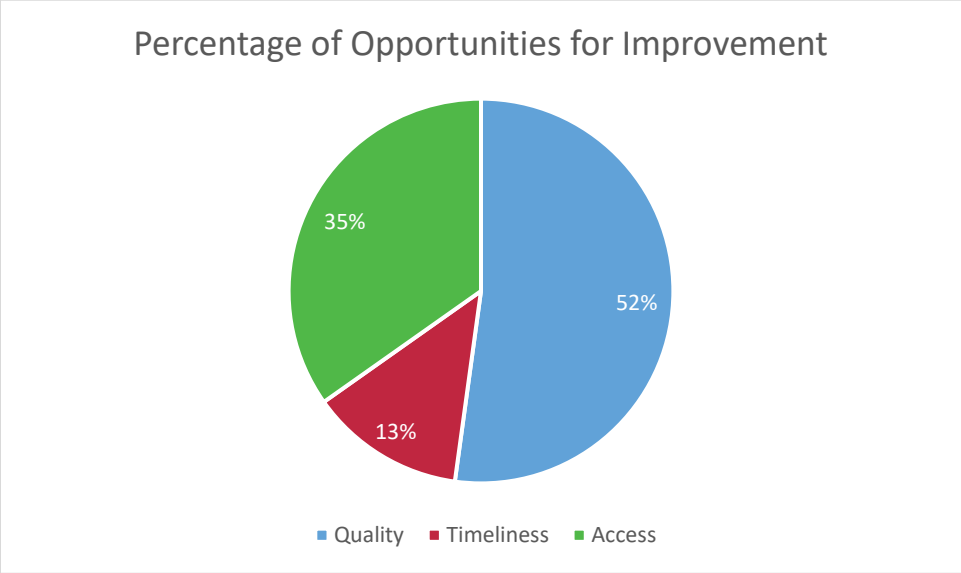
Region 1—Rocky Mountain Health Plans

Figure 4-1—Percentage of Strengths by Care Domain for RMHP*



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

Figure 4-2—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, timeliness, and accessibility of care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, RMHP established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-1 and Table 4-2 summarize RMHP's PIP activities that were completed and validated in FY 2020–2021. Table 4-1 provides the SMART Aim statements that RMHP defined for the two PIP outcome measures in Module 1.

Table 4-1—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 4-2 summarizes the preliminary key drivers and potential interventions RMHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-2—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.

Table 4-3 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-3—Intervention Testing Plan 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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
			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 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

FY 2022–2023 PIP Activities

In FY 2022–2023, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed RMHP's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated RMHP's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for RMHP's PIP are presented in Table 4-4. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-4—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings completed among RAE members attributed to either SMFM or MFHC ages 12 years and older.	0.63%	20.00%	2.98%	*Yes*
Follow-Up After a Positive Depression Screen				
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.	28.57%	46.89%	88.64%	*Yes*

To guide the project, RMHP established goals of increasing the percentage of members 12 years of age and older, attributed to SMFM or MFHC, who received a depression screening from 0.63 percent to 20.00 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 28.57 percent to 46.89 percent, through the SMART Aim end date of June 30, 2022. RMHP's reported SMART Aim measure results for the *Depression Screening* measure demonstrated a statistically significant improvement of 2.35 percentage points from baseline to the highest rate achieved, 2.98 percent; however, the SMART Aim goal was not achieved. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 88.64 percent, exceeded the goal and represented a statistically significant improvement of 60.07 percentage points over the baseline rate.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, RMHP completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-5 summarizes RMHP's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-5—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
MFHC Intervention 1: Develop, implement, and train MAs and providers on a new workflow to score, document, and accurately code depression screens with a negative result (G8510) and positive result (G8431).	Significant *programmatic* improvement for *Depression Screening*	Adopted
SMFM Intervention 1: Integrate G-codes into workflow to ensure proper measurement capture of G8431 and G8450. Review and revise SMFM workflow for using G-codes.	*None*	Abandoned
MFHC Intervention 2: Develop and deploy a registry for patients who score positive on the Patient Health Questionnaire (PHQ-9) to guide BHAs to connect to patients for BH follow-up when appropriate.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
SMFM Intervention 2: Create a standardized depression screening billing and CPT coding workflow for the partner provider.	*None*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

RMHP: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP developed and carried out a methodologically sound improvement project.
- RMHP accurately reported SMART Aim measure and intervention testing results.

- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure and achievement of the SMART Aim goal for the *Follow-Up After a Positive Depression Screen* measure.
- RMHP's intervention testing results demonstrated programmatically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, RMHP's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of RMHP's PIP, HSAG recommended:

- 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.

Assessment of RMHP's Approach to Addressing FY 2021–2022 PIP Recommendations

RMHP successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.

- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-6 shows the performance measure results for RMHP for MY 2020 through MY 2022.

Table 4-6—Performance Measure Results for RMHP

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	41.72%	47.90%	53.73%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	47.66%	44.48%	50.81%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	30.85%	32.46%	35.88%	48.22%
Follow-Up After a Positive Depression Screen	51.47%	57.49%	61.40%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.57%	16.39%	13.17%	30.56%

RMHP: Strengths

The following performance measure rates for MY 2022 increased from the previous year for RMHP:

- *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* 

Additionally, the following performance measure rate for MY 2022 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment* 

RMHP: 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*
- *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:

- Complete further expansion on the performance-based dashboard to include thresholds to notify shifts in performance rates.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of RMHP's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, RMHP reported implementing the following:

- A monthly dashboard to monitor, track, and trend performance measures.

- A BHIP expansion project that kicked off in the fall of 2022 and launched in early 2023, which incentivized PCMPs and independent provider network (IPN) providers for being open to referrals and completing encounters in the time frame for the measures.
- For the *Engagement in Outpatient SUD Treatment* indicator, RMHP reported the following interventions:
  - The creation of a cheat sheet for providers was created to assist with implementing best practices and workflows.
  - Distributing performance data to key stakeholders monthly.
  - Monthly discussions with quality teams to discuss data dashboards, answer questions/concerns, and discuss barriers and best practices with CMHCs.
- For the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* indicator, RMHP reported implementing the following interventions:
  - Distributing performance data to key stakeholders monthly.
  - Monthly discussions with quality teams to discuss data dashboards, answer questions/concerns, and discuss barriers and best practices with CMHCs.
  - Added a census report to Essette CM platform to track patients who need follow-up care.
  - Worked with the Health Information Exchange, Quality Health Network, to utilize available data to ensure they are being incorporated into tracking.
  - The CM team dedicated a full-time resource to conduct proactive outreach to ensure follow-up visits were scheduled with a provider within the seven-day time frame.
  - Created an incentive for primary care and the IPN providers that was established at the end of the fiscal year.
  - Credentialed a telehealth provider to assist with access for the seven-day follow-up time frame.
  - Expedited credentialing for providers at the end of the fiscal year to increase access.
  - Mind Springs (a CMHC) reviewed its internal processes around this measure and identified barriers and successes that it shared with other CMHCs.
- For the *Follow-Up Within 7 Days of an ED Visit for SUD* indicator, RMHP reported implementing the following interventions:
  - Distributing performance data to key stakeholders monthly.
  - Monthly discussions with quality teams to discuss data dashboards, answer questions/concerns, and discuss barriers and best practices with CMHCs.
  - The utilization management team developed and implemented a new process in which follow-up visits are scheduled at admission rather than after discharge.
  - Provided member gift cards through the Steadman Group to encourage completion of follow-up visits.
  - The CMHCs agreed to prioritization of this measure during the month of June to push timely patient follow-up.

- For the *Follow-Up After a Positive Depression Screen* indicator, RMHP reported implementing the following interventions:
  - Distributing dashboard data to key stakeholders.
  - Monthly discussions with quality teams to discuss data dashboards, answer questions/concerns, and discuss barriers and best practices with CMHCs.
  - Tracking and monitoring the use of the required "g-codes" for this measure.
  - Expanded access to the annual Behavioral Health Skills Training learning collaborative to CMHCs.
  - Created a "one-pager" on this measure and presented to primary care and CMHCs.
  - Updated and disseminated the Depression Screening Toolkit to providers.
  - Distributed articles in the Provider Insider Plus monthly newsletter.
  - Mind Springs (a CMHC) collected data to track how many PCPs were referring to it for a positive screen.
- For the *Behavioral Health Screening or Assessment for Children in the Foster Care System* indicator, RMHP reported implementing the following interventions:
  - Distributing dashboard data to key stakeholders.
  - Monthly discussions with quality teams to discuss data dashboards, answer questions/concerns, and discuss barriers and best practices with CMHCs.
  - Summit Stone (a CMHC) developed flyers to promote education on this measure during the CMHC collaborative.
  - RMHP Care Management collaborated with Mesa County Department of Human Services (DHS) to improve processes for foster children in Mesa County.

HSAG recognizes that the implementation of the dashboard and the gift card promotion are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Overall Evaluation

Table 4-7 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-7—Summary of RMHP Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	33	2	0	0	94%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**86**	**86**	**81**	**5**	**0**	**0**	**94%***

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

Table 4-8 presents the compliance scores for record reviews conducted for RMHP during FY 2022–2023.

Table 4-8—Summary of RMHP Scores for the FY 2022–2023 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	70	67	3	30	96%
Grievances	60	52	52	0	8	100%
Appeals	60	58	54	4	0	93%
Totals	**220**	**180**	**173**	**7**	**38**	**96%***

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

RMHP: Trended Performance for Compliance With Regulations

Table 4-9 presents, for all standards, the overall percentage of compliance score for RMHP for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-9—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; 2022–2023)	**90%**	**94%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**100%**	**92%**
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; 2022–2023)	**86%**	**94%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, each of the four standards reviewed for RMHP demonstrated consistent high-achieving and improved scores from the previous review cycle for two standards. Standard II—Adequate Capacity and Availability of Services declined by 8 percentage points but scored relatively high, demonstrating a general to strong understanding of most federal and State regulations.

RMHP: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for RMHP:

- UM documentation within the denial samples demonstrated extensive outreach to the provider when additional information or clarification was needed. Most files included at least two outreaches and some files included 10 or more documented efforts. Some NABDs included clear recommendations for the member to obtain the recommended alternative LOC and listed available providers in the area, including contact information.
- Leadership noted a significant network gain with a provider who serves the Delta, Gunnison, and Montrose regions.
- Cultural competency trainings, outreach, and initiatives submitted in documentation and described by staff members were extensive and specifically targeted to its membership. To encourage participation in its extensive cultural competency initiatives and ensure that members feel comfortable accessing care, RMHP demonstrated a tiered VBP initiative that has been expanded to encourage psychosocial screeners, representation of diverse membership on patient and family advisory councils, and providers' enhanced ability to report on member satisfaction measures.
- RMHP has a grievance system in place to receive, log, and track a grievance request from the member at any time. RMHP submitted a full sample of 10 grievances that met 100 percent compliance for readability and timeliness of acknowledgment and resolution letters.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to RMHP's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Many of the NABDs reviewed included acronyms or clinical terminology that could be explained in a more member-friendly manner.
- RMHP identified a large-scale issue related to member claims denial notices. Staff members described that a glitch in the member letter file did not trigger the next step to notify the support services team, which processes and mails the member letters.
- The *UM Program Description* included incorrect authorization timelines that miscommunicated the timeline from the time of the decision or after the time of verbal notification.
- Quarterly network reports indicated an opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for SUD general and pediatric

treatment providers and for treatment facilities (i.e., ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM), psychiatric hospitals, and psychiatric units in acute care hospitals. 🔑

- The *Standards for Practitioner Office Sites* policy incorrectly stated the time frame for urgent and non-urgent care visits, and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits. ⏱️🔑
- RMHP's *UM Program Description* incorrectly stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider.

To address these opportunities for improvement, HSAG recommends RMHP:

- Perform additional internal review and expand plain language explanations in a more member-friendly manner, whenever possible.
- Engage in long-term monitoring as part of the CAP process.
- Update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.
- Update the *Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and include the exceptions related to the American Academy of Pediatrics Bright Futures Periodicity Schedule when well-care visits should be scheduled prior to one month.
- Remove any references that require a member to submit appeal information in writing.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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.

Assessment of RMHP's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, RMHP updated 10 of its required member informational materials, updated policies to correctly detail the timeline to notify members of a terminated provider, and expanded its UM practices to include additional documentation about EPSDT medical necessity considerations. HSAG recognizes that the informational and policy updates are likely to result in long-term improvements, and the updated UM documentation protocol is likely to result in long-term improvements with ongoing monitoring.

Validation of Network Adequacy

RMHP: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP met all minimum network requirements for Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS), Family Practitioners (MD, DO, NP, CNS), General and Pediatric Behavioral Health Practitioners, General and Pediatric Psychiatrists and other Psychiatric Prescribers, and General and Pediatric SUD Treatment Practitioners in all rural and frontier counties.
- In the rural county for which RMHP did not meet the minimum network requirements for Adult Primary Care Practitioners (PA) and Family Practitioners (PA), the access level was greater than 99.9 percent. In the frontier county for which RMHP did not meet the minimum network requirements for Adult Primary Care Practitioners (PA), Pediatric Primary Care Practitioners (PA), and Family Practitioners (PA), access was greater than 96 percent for each provider category.
- Overall, 83.2 percent of RMHP's sampled providers were found in the online provider directory and at the sampled location.
- RMHP had match rates above 90 percent for nine out of 10 PDV indicators.

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 network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any of the contracted frontier or rural counties.
- RMHP did not meet the minimum network requirements for numerous SUD Treatment Facilities ASAM LOCs across multiple contracted rural and frontier counties.

- RMHP had a match rate of 80.1 percent for the practitioner's name or business name indicator, exhibiting the lowest overall match rate for this indicator across all RAEs.

To address these opportunities for improvement, HSAG recommends RMHP:

- Continue to conduct an in-depth review of provider categories for which RMHP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, RMHP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that RMHP seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of RMHP's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, RMHP reported taking the following actions:

- RMHP maintained an open network policy for all providers within the contracted service area who meet RMHP credentialing and quality standards. Given the rural and frontier nature of RMHP's service area, RMHP reports few new providers entering the region.
- RMHP continued to expand a pilot project for e-consultants, which provides PCP access to specialist consultations with providers outside of members' immediate area, as well as outside of RMHP's service area in select cases.

Based on the above response, RMHP worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-10 presents RMHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-10—FY 2022–2023 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	71.5%	92.0%
Diagnosis Code	90.5%	75.2%	89.8%
Place of Service	NA	67.2%	92.0%
Service Category Modifier	NA	76.6%	92.0%
Units	NA	72.3%	92.0%
Revenue Code	99.3%	NA	NA
Discharge Status	95.6%	NA	NA
Service Start Date	97.8%	76.6%	92.0%
Service End Date	99.3%	76.6%	92.0%
Population	NA	76.6%	92.0%
Duration	NA	75.2%	92.0%
Staff Requirement	NA	75.2%	92.0%

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

Table 4-11 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 4-11—FY 2022–2023 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%	100.0%
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	90.0%	100.0%	100.0%
Service End Date	90.0%	100.0%	100.0%
Population	NA	100.0%	100.0%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
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.

RMHP: Strengths

Based on RAE 411 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP self-reported high overall accuracy for inpatient services and residential services, with 90 percent accuracy or above for all five inpatient services data elements and nine of the 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that RMHP's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with three of the five inpatient services data elements, all 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in RMHP's EDV results, RMHP's self-reported EDV results for psychotherapy services demonstrated a low level of encounter data accuracy, with results ranging from 67.2 percent for the *Place of Service* data element to 76.6 percent for the *Service Category Modifier*, *Service Start Date*, *Service End Date*, and *Population* data elements.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended RMHP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of RMHP's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

RMHP reported implementing three initiatives to improve performance: training for reviewers, peer review of all EDV failures at weekly IRR meetings, and implementation of a standardized audit tool. Additionally, RMHP provided individualized results to impacted providers, and met with individual providers upon request to review failures and to provide education on common billing, coding, and documentation errors, and best practices. RMHP also reported taking steps to improve provider response rates for the FY 2022–2023 EDV.

Based on RMHP's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

RMHP: Adult CAHPS

Table 4-12 shows the adult CAHPS results for RMHP for FY 2021–2022 and FY 2022–2023.

Table 4-12—Adult CAHPS Top-Box Scores for RMHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	58.2%	54.9%
Rating of All Health Care	59.5%	48.6%
Rating of Personal Doctor	71.1%	63.4%
Rating of Specialist Seen Most Often	68.8%+	64.5%+
Getting Needed Care	79.5%+	79.3%
Getting Care Quickly	76.6%+	79.9%+
How Well Doctors Communicate	90.3%+	96.9%+ ▲ ↑
Customer Service	84.1%+	82.9%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

RMHP: Strengths

The following measure's FY 2022–2023 score for RMHP was statistically significantly higher than the 2022 NCQA national average and FY 2021–2022 score:

- *How Well Doctors Communicate*

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

Every measure's FY 2022–2023 score for RMHP, except *How Well Doctors Communicate*, was lower, although not statistically significantly, than the 2022 NCQA national average.

Every measure's FY 2022–2023 score for RMHP, except *Getting Care Quickly* and *How Well Doctors Communicate,* were lower, although not statistically significantly, than the FY 2021–2022 score.

To address these low CAHPS scores, HSAG recommends RMHP:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality, timeliness, and accessibility of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Consider any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

RMHP: Child CAHPS

Table 4-13 shows the child CAHPS results for RMHP for FY 2021–2022 and FY 2022–2023.

Table 4-13—Child CAHPS Top-Box Scores for RMHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	67.4%	71.0%
Rating of All Health Care	64.9%	68.0%
Rating of Personal Doctor	78.1%	71.9%
Rating of Specialist Seen Most Often	55.2%+	66.0%+
Getting Needed Care	77.0%+	82.3%
Getting Care Quickly	85.0%+	88.8%
How Well Doctors Communicate	93.2%	95.2%
Customer Service	84.0%+	85.7%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

RMHP: Strengths

The following measures' FY 2022–2023 scores for RMHP were higher, although not statistically significantly, than the 2022 NCQA national averages:

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

Every measure's FY 2022–2023 score for RMHP, except *Rating of Personal Doctor*, was higher, although not statistically significantly, than the FY 2021–2022 score.

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

Every measure's FY 2022–2023 score for RMHP, except *Getting Care Quickly* and *How Well Doctors Communicate,* was lower, although not statistically significantly, than the 2022 NCQA national average.

The following measure's FY 2022–2023 score for RMHP was lower, although not statistically significantly, than the FY 2021–2022 score:

- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends RMHP:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality, timeliness, and accessibility of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for parents/caretakers of child members.
- Direct parents/caretakers to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, RMHP reported engaging in the following QI initiatives:

- Implemented a process within customer service to notify Provider Relations and the Value Based Contracting Review Committee (VBCRC) when it is informed by members that a healthcare provider is not accepting new patients or is requiring applications for acceptance. Provider Relations follows up with the provider to investigate and address members' concerns. Additionally, this is tracked in the VBCRC to evaluate objectively if the practices are meeting the openness to Medicaid requirements based on their value-based contracts.
- During member welcome calls, Customer Service educates members on the importance of having a primary care relationship with a PCP. Customer Service asks members if they have a PCP and if they have an appointment coming up. If a member does not have a PCP, Customer Service offers to help the member find one and connect with the office to schedule an appointment.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, more in the last year. This included member mailers and emails, adding quick-response (QR) codes to existing mailers, and business cards for care coordinators and external stakeholders to distribute with CirrusMD for information.

- Included member experience topics in newsletter articles, learning collaborative events, and webinar series. Topics included leadership training, BH skills training, and CM training.
- Provided cultural competency training to providers at health equity training, CM training, and BH skills training.
- Expanded the eConsult program 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, empower the primary care practice, and increase education/clinical pathways within primary care.
- Implemented a structure within the RAE value-based contracts that includes an integrated BH component where CAHPS scores are considered. Practices are now held accountable in their value-based contracts to CAHPS scores. This allows RMHP to support practices in patient experience strategies that may yield positive CAHPS results and satisfaction with providers year over year.

Assessment of RMHP's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that RMHP addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with RMHP.

Quality Improvement Plan

Table 4-14 presents RMHP's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-14—Summary of RMHP QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Procedure Code	88%	NA	NA	100%
	Primary Diagnosis Code	74%	100%	100%	90%
	Revenue Code	74%	100%	100%	100%
	Discharge Status	78%	100%	67%	100%
	Service Start Date	80%	100%	100%	100%
	Service End Date	80%	100%	100%	80%
Psychotherapy Services	Procedure Code	60%	0%	100%	86%
	Diagnosis Code	61%	0%	100%	57%
	Place of Service	56%	100%	100%	43%
	Service Category Modifier	64%	100%	100%	86%
	Units	61%	0%	0%	57%

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
	Service Start Date	64%	100%	100%	86%
	Service End Date	64%	100%	100%	86%
	Population	64%	100%	100%	86%
	Duration	61%	0%	0%	57%
	Staff Requirement	63%	100%	100%	86%
Residential Services	Procedure Code	39%	100%	100%	100%
	Diagnosis Code	39%	0%	100%	100%
	Place of Service	30%	100%	100%	100%
	Service Category Modifier	35%	100%	100%	100%
	Units	39%	100%	100%	100%
	Service Start Date	39%	100%	100%	100%
	Service End Date	39%	100%	100%	100%
	Population	39%	100%	100%	100%
	Duration	39%	100%	100%	100%
	Staff Requirement	34%	100%	100%	100%

**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 2022–2023, HSAG found the following strengths for RMHP:

- RMHP reached above 90 percent accuracy for 15 of 26 of the data elements across three claim types included in the QUIP. Most notably, all 10 data elements for residential services started with a baseline around 30 percent and improved significantly above the 90 percent threshold, maintaining that increase by the end of the QUIP project.
- Key interventions included training for providers, which included the distribution of educational materials that reminded providers of the regulatory and contractual requirements to submit the requested documentation, and CAPs implemented for record collection to improve documentation.
- HSAG offered RMHP additional time to collect medical records, after which RMHP was able to confirm improvements in the inpatient services and residential services claim types due to additional time to collect data.

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

HSAG found the following opportunities for improvement:

- For the psychotherapy services claim type, some data elements showed little or no improvement, and one of the three pilot partners was still nonresponsive to the request for 10 medical records.
- Eleven data elements remained below the target threshold of 90 percent accuracy.

To address these opportunities for improvement, HSAG recommends RMHP:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that 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.

Assessment of RMHP's Approach to Addressing FY 2021–2022 QUIP Recommendations

RMHP reported that its monitoring and audit program conducts quarterly audits to educate and inform providers on billing, coding, and documentation standards. RMHP has responded to each component of HSAG's FY 2021–2022 QUIP recommendations. HSAG recognizes that timely and consistent auditing, paired with feedback, is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-15 displays the MHP Audit compliance scores for RMHP for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-15—FY 2022–2023 MHP Audit Score for RMHP

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
RMHP	1	91%	Inpatient	99%	99%^
			Outpatient	100%	

^ *Indicates that the score increased as compared to the previous review year.*

RMHP: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP demonstrated an overall score of 99 percent, an 8 percentage point increase from FY 2021–2022.
- RMHP used nationally recognized UR criteria, including MCG, for all MH determinations and ASAM LOC 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 a minimum passing score of 80 percent.
- 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 and services.
- For all 10 inpatient and 10 outpatient records reviewed, RMHP made the denial determinations within the required time frame, and providers were notified of the denial determinations through telephone and received a copy of the NABD.
- All records reviewed demonstrated that the member was sent the NABD within the required time frame.
- In all records reviewed, the denial determination was made by a qualified clinician and contained evidence that RMHP offered a peer-to-peer review to the requesting provider.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in RMHP's UM system.

- RMHP's NABDs included the required content such as the member's appeal rights, rights to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP when filing, access to pertinent records, and the reason for denial. Additionally, all NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
- During the MHP interview, RMHP reported continued training and education for providers regarding ASAM LOCs and how to submit proper and thorough documentation requests for review. RMHP included ASAM training videos on the website and provided more direct virtual training opportunities with providers regarding administrative documentation needs to ensure sufficient and complete requests for authorizations.

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

HSAG found the following opportunities for improvement:

- RMHP did not list the required ASAM dimensions and how they were considered when determining medical necessity in one SUD inpatient NABD reviewed by HSAG.
- Some NABDs listed the requested service date as the date the denial determination was made. Per guidance from the Department and as a best practice, the date the MCE denied the request should be the date of the denial determination for a new request for service or the date the current authorization expires (of the first non-authorized date) for concurrent/continued requests.

To address these opportunities for improvement, HSAG recommends RMHP:

- Train staff members and conduct record review audits periodically to ensure all inpatient and residential SUD NABDs list the required ASAM dimensions and how the dimensions were considered when determining medical necessity.
- Update the NABD template to ensure language regarding the date of the denial determination is used correctly and train staff members about this distinction.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of RMHP's Approach to Addressing FY 2021–2022 MHP Recommendations

RMHP reported addressing HSAG's recommendations by:

- Providing job aids and a turnaround time grid to UM staff members to assist with meeting the required time frames. Additionally, both BH and PH UM managers receive a monthly timeliness report that identifies all untimely cases. Staff members are coached one-on-one if they have an untimely case.
- Training UM staff members about which template to use for NABDs. RMHP reported that both BH and PH UM teams conduct monthly audits for cases to ensure the correct template is used consistently.
- Reminding UM staff members of the requirement to document when a peer-to-peer review is offered to a provider. The requirement is also listed in the RMHP policy, and RMHP reported that both BH and PH UM teams conduct monthly audits on cases to ensure that this policy is followed consistently.

HSAG anticipates RMHP's response to the recommendations are likely to improve overall processes and increase MHP compliance. RMHP should continue addressing the recommendations made by HSAG for continuous improvement and staff enrichment.

QOC Concern Audit

The QOC Concern Audit was not conducted with RMHP in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended RMHP:

- Develop and implement ongoing staff training on the Colorado-specific QOC grievance 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 QOC grievances.
  - Incorporate contract requirements.
  - Add severity levels and definitions.
  - Include a process for reporting to the Department.
  - Incorporate a process for acknowledgement and resolution letters.
  - Establish milestones/timelines/time frames and/or goals for the QOC grievance process.

- Consider consistently requesting evidence of CAP completion from a facility/provider when a CAP is initiated. For example, if the facility indicated that it 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 QOC grievances received. Additionally, HSAG recommended RMHP 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 QOC grievance for all QOC grievances, regardless of who reported the QOC grievance referral.
- Follow up with its contract managers at the Department to resolve questions regarding whether RMHP should conduct QOC grievances that are related to dental services since RMHP is not the payor for dental services.

Assessment of RMHP's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

RMHP reported addressing HSAG's recommendations by:

- Updating and finalizing policies and procedures for the QOC grievance process.
- Reviewing QOC grievance activities and processes at the Medical Peer Review Committee and Quality Improvement Committee (QIC).
- Dedicating a staff member to liaise between the appeal and grievance teams and medical director.
- Alerting and consulting the Department for the processing and resolving of any issues that arise involving dental services.
- Sending monthly closed case lists to the Department to provide visibility. RMHP stated that all alerts are provided in real time for escalated concerns.

HSAG anticipates RMHP's responses to the recommendations are likely to improve overall processes and alignment with contractual requirements. RMHP should continue addressing the recommendations made by HSAG and prepare for guidance from the Department for upcoming contractual changes and requirements.

EPSDT Audit

Table 4-16 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-16—FY 2022–2023 EPSDT Audit Findings for RMHP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	67%	88%
Post-Denial Record Review	92%	75%	85%

RMHP: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- Policies, procedures, trainings, and programs supported by RMHP included all aspects of the EPSDT definition of medical necessity. RMHP's efforts to document the full definition of medical necessity for EPSDT were the most successful across the MCEs.
- UM staff members thoroughly reviewed the member's needs, the purpose of the service, if the service was appropriate, if the member had any past or concurrent treatment, family support, and member-specific information (triggers and stressors, medication management/compliance, symptoms/behaviors, etc.).
- RMHP engaged in a multi-phased training for EPSDT from 2019 through 2022; the trainings were recorded and available on the RMHP website, and providers were reminded of the trainings through newsletters. Trainings included Comprehensive Benefit and Prior Authorization, Outreach and Education, and a Family Voices Colorado external presenter. Additionally, UM staff members received an email reminder for internal EPSDT trainings that included an additional review of EPSDT medical necessity criteria.
- RMHP outreached members through the use of welcome calls which followed scripts that included screening questions to assess whether SHCN or health risks were present.
- All RMHP members reviewed for the non-utilizer sample received at least one outreach during the review period. RMHP used a combination of strategies to determine members who needed non-utilizer outreach during the review period.

- RMHP reported goals to introduce text messaging options to improve communication and engagement, and staff members reported an increase in contact rates up to 80 percent in more recent months.
- RMHP was one of the only MCEs that utilized an EPSDT flyer to explicitly mention lead screening.
- In all NABDs reviewed, RMHP used the Department's template. In most cases reviewed, RMHP included EPSDT information specific to the member's situation and included member-specific details.
- RMHP's care coordination letter titled "Sorry We Missed You" included EPSDT information and the EPSDT flyer, which HSAG recognized as a best practice.

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

HSAG found the following opportunities for improvement:

- RMHP reported automated phone calls, mailed letters, and emails had a 0 percent completion rate, and RMHP did not have a method to track the delivered and/or "open" rate for emails.

To address these opportunities for improvement, HSAG recommends RMHP:

- Engage in additional discussions with the Department regarding any updates to tracking completion rates for RMHP outreach efforts.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- Although RMHP provided evidence that there were 10 welcome calls attempted and five were successful for members reviewed in the sample, there were no risk assessments on file for the 15 non-utilizer sample members reviewed.
- RMHP did not have a process for comparing returned mail rates to the number of mailings sent. Policies, procedures, the quarterly report, and staff members described procedures for emails and phone outreach; however, none of these methods were observed within the non-utilizer sample.
- Only some of the NABDs outlined specific next steps for the member (i.e., facility or organization where the member could receive the recommended LOC and phone number). None of the NABDs included information about receiving assistance with scheduling appointments and transportation; any additional assistance offered occurred when the care manager outreached the member separately from the NABD process. Additionally, RMHP's policies did not include details about including any specific next steps for the member or offering assistance with scheduling appointments and transportation.
- RMHP did not always refer the member to care coordination after issuing a denial.

Although these findings did not lead to recommendations, HSAG informed RMHP of these findings within the report. RMHP should work on addressing these findings to improve processes, procedures, and communication with the Department.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-17 presents the number of cases in the sample that HSAG reviewed for RMHP and the percentage of cases in which HSAG reviewers agreed with RMHP's denial determination.

Table 4-17—RMHP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
RMHP	18	18	100%

RMHP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP was the only MCE in the sample to use extensions. HSAG recognizes this approach as a best practice to allow for additional time to obtain necessary clinical documentation and fully assess medical necessity in some situations. 
- RMHP included detailed notes to document when the NABDs were mailed, and HSAG recognizes this as a best practice. 

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- In four of the 18 cases, the files did not include a copy of the member's NABD. In these cases, the member was notified of the denial via a copy of the notice of denial sent to the provider facility; however, not all required member content was included in the provider letter. 

To address these opportunities for improvement, HSAG recommends RMHP:

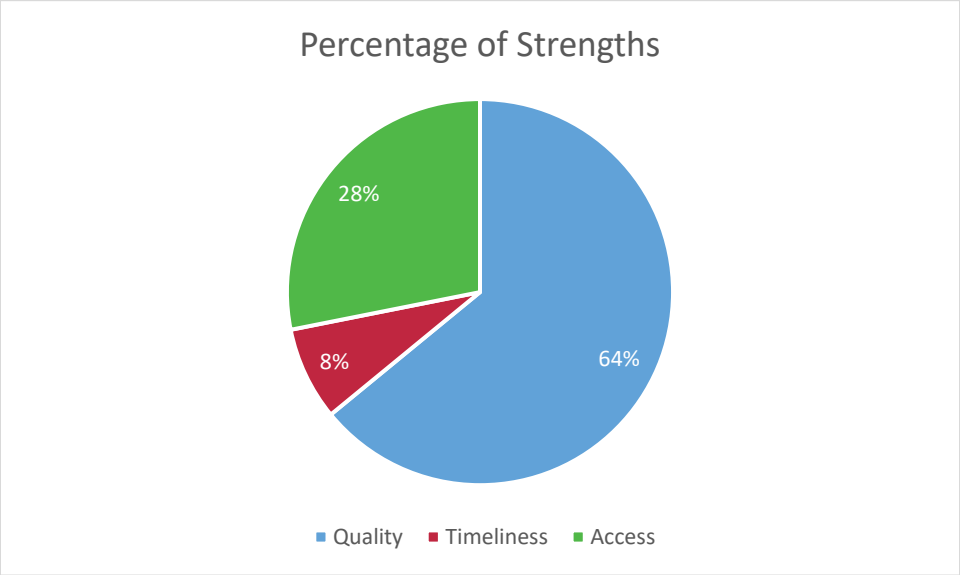
- Update policies, procedures, and processes to ensure that members receive the correct NABD template.
- Use a member-specific NABD to ensure that member communications regarding adverse benefit determinations include:
  - A description of ASAM dimensions.
  - The member's right to an appeal and expedited appeal.
  - The member's right to free copies of documentation.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

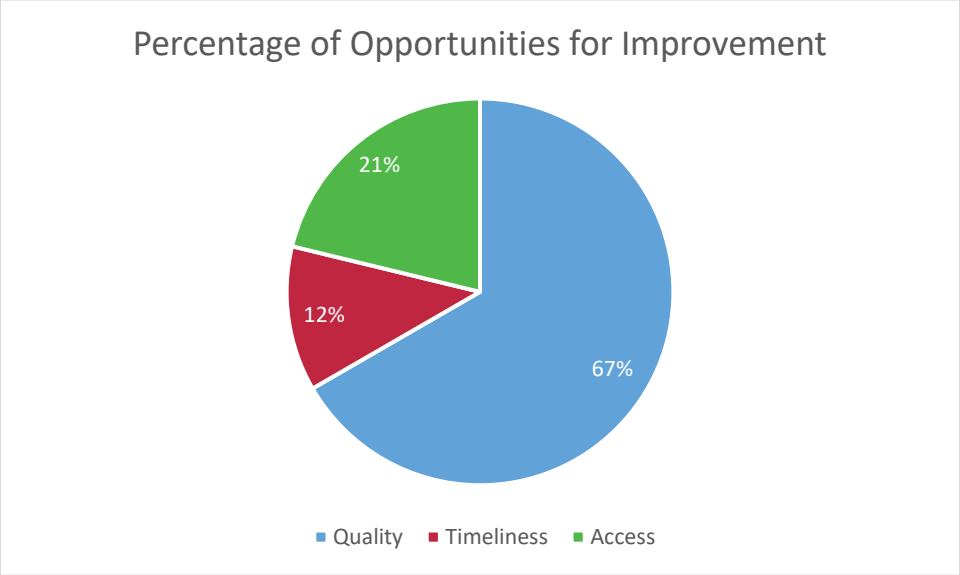
Region 2—Northeast Health Partners

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



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

Figure 4-4—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, timeliness, and accessibility of care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, NHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, NHP established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-18 and Table 4-19 summarize NHP's PIP activities that were completed and validated in FY 2020–2021. Table 4-18 provides the SMART Aim statements that NHP defined for the two PIP outcome measures in Module 1.

Table 4-18—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 4-19 summarizes the preliminary key drivers and potential interventions NHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-19—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.

Table 4-20 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-20—Intervention Testing Plan 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

FY 2022–2023 PIP Activities

In FY 2022–2023, NHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed initial Module 4 submission form, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

HSAG analyzed NHP's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated NHP's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for NHP's PIP are presented in Table 4-21. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-21—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC), ages 12 years and up.	84.04%	85.06%	87.40%	Yes
Follow-Up After a Positive Depression Screen				
The percentage of behavioral health (BH) follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC, ages 12 years and up.	40.22%	47.66%	49.00%	No

To guide the project, NHP established goals of increasing the percentage of members 12 years of age and older, attributed to Sunrise Community Health, who received a depression screening during an outpatient visit at MFC, from 84.04 percent to 85.06 percent, and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 40.22 percent to 47.66 percent, through the SMART Aim end date of June 30, 2022. NHP's reported SMART Aim measure results demonstrated that the SMART Aim goals were exceeded for both measures. For the *Depression Screening* measure, the highest rate achieved, 87.40 percent, represented a statistically significant increase of 3.36 percentage points above the baseline rate. For the *Follow-Up*

After a Positive Depression Screen measure, the highest rate achieved, 49.00 percent, represented an increase of 8.78 percentage points above the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, NHP completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-22 summarizes NHP's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-22—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Staff feedback on depression screening performance and training on depression screening procedures.	Significant *clinical* and *programmatic* improvement for *Depression Screening*	Adopted
Establish a clinical policy for BH referral after a positive depression screen, and provide staff training on the BH referral policy and procedures following a positive depression screen.	Significant *clinical* and *programmatic* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

NHP: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- NHP developed and carried out a methodologically sound improvement project.
- NHP accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results achieved the SMART Aim goals for both the *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures and demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure.

- NHP's intervention testing results demonstrated clinically and programmatically significant improvement linked to the tested interventions for both the *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures.

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

Based on PIP validation activities conducted in FY 2022–2023, NHP's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of NHP's PIP, HSAG recommended:

- 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.

Assessment of NHP's Approach to Addressing FY 2021–2022 PIP Recommendations

NHP successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-23 shows the performance measure results for NHP for MY 2020 through MY 2022.

Table 4-23—Performance Measure Results for NHP

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	42.34%	50.80%	54.11%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	74.23%	50.07%	49.78%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	39.25%	29.64%	28.41%	48.22%
Follow-Up After a Positive Depression Screen	53.25%	87.09%	83.84%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	23.00%	18.60%	14.57%	30.56%

NHP: Strengths

The following performance measure rate for MY 2022 increased from the previous year for NHP:

- *Engagement in Outpatient SUD Treatment*

Additionally, the following performance measure rates for MY 2022 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*
- *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:

- *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.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of NHP's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, NHP reported that it held quarterly meetings with RAE leadership. At these meetings, performance reports on the BHIP measures were provided specific to each CMHC's performance. These reports provided the opportunity to identify trending as well as detailed member-level data that CMHCs may utilize to investigate performance improvement opportunities.

NHP still has the opportunity to address HSAG's prior recommendation of creating a dashboard to monitor rates monthly or quarterly. Monitoring of rates throughout the year can help create greater visibility and timelier interventions. The ability to stratify the rates across multiple variables such as county, ZIP Code, rendering provider, etc. can help NHP identify more targeted opportunities for improvement. NHP should address the recommendations made by HSAG in an effort to continue to improve upon its rates.

Assessment of Compliance With Medicaid Managed Care Regulations

NHP Overall Evaluation

Table 4-24 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-24—Summary of NHP Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	29	3	0	0	91%
II. Adequate Capacity and Availability of Services	14	14	13	1	0	0	93%
VI. Grievance and Appeal Systems	35	35	32	3	0	0	91%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**79**	**7**	**0**	**0**	**92%***

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

Table 4-25 presents the compliance scores for record reviews conducted for NHP during FY 2022–2023.

Table 4-25—Summary of NHP Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	70	57	13	30	81%
Grievances	60	50	49	1	10	98%
Appeals	60	60	60	0	0	100%
Totals	**220**	**180**	**166**	**14**	**40**	**92%***

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

NHP: Trended Performance for Compliance With Regulations

Table 4-26 presents, for all standards, the overall percentage of compliance score for NHP for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-26—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; 2022–2023)	**97%**	**91%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**94%**	**93%**
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; 2022–2023)	**77%**	**91%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, NHP demonstrated consistent moderate to high-achieving scores from the previous review cycle, indicating a strong understanding of most federal and State regulations.

NHP: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for NHP:

- UM staff members described innovations which included adding automation solutions to the Provider Connect system to improve providers' experiences requesting services; reducing barriers for prior-authorization requests, where appropriate; and working to educate providers about

frequently requested services such as methadone, MAT, and other SUD services, which have continued to increase since the implementation of the SUD benefit.

- UM team participated in annual IRR assessments and met the 80 percent passing rate during the review period.
- Policies, procedures, network adequacy quarterly reports, and geoaccess compliance reports all demonstrated that NHP made efforts to contract with each specialty type required by the contract and expand its provider network quarter over quarter.
- Community outreach managers were trained to educate members of their rights to appeal and to request a State fair hearing as well as communicate to the member the limited time frame to receive additional evidence to support the member's appeal request.
- NHP maintains a panel of peer advisors with clinical expertise to review appeals and make decisions regarding the information collected during the request. Three out of 10 appeal sample records were expedited, and Beacon staff members made a reasonable effort to contact the member about the resolution within the 72-hour time frame.
- Member letters were written in an easy-to-understand language and met the sixth-grade reading level requirement.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to NHP's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Three denial decisions in the sample were not made within timeliness requirements, and all three were related to SUD residential or inpatient LOCs, which are required within 72 hours.
- Five out of 10 NABDs reviewed were sent to the member outside of timeliness requirements.
- Physical health and behavioral health time and distance standards not met during FY 2022–2023 Q1 nearly reached 100 percent compliance (96 percent to 99.7 percent) in the urban area of Weld County, excluding psychiatric hospitals or psychiatric units in acute care facilities, which only met 21 percent coverage.
- In rural and frontier counties, psychiatric hospitals and psychiatric units in acute care facilities and ASAM LOCs 3.1, 3.2 WM, 3.3, 3.7, and 3.7 WM had almost no access in Logan, Phillips, Cheyenne, Kit Carson, Sedgwick, and Yuma counties, specifically.

- NHP's PCP Practitioner Agreement included two incorrect time frames: urgent care was listed as 48 hours instead of 24 hours, and well visits were listed as 45 days instead of one month.
- One out of 10 grievance sample records did not include the disposition in the member resolution letter.
- Some documentation incorrectly stated that a verbal appeal request should be followed by a written request, or the coordinator should reach out to the member to obtain a signed appeal.
- NHP's Appeals Policy did not state that the coordinator will make a reasonable attempt to contact the member to notify the member of the delay when an extension is used.
- NHP did not have a mechanism to compare disenrollment files to member-reported QOC concerns for tracking and trending purposes.

To address these opportunities for improvement, HSAG recommends NHP:

- Enhance its procedures and monitoring to ensure that all denial decisions are made within time frame requirements.
- Update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the denial decision time frame is based on the date of the service request until the deadline.
- Enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners and psychiatric units in acute care hospitals.
- Correct the timely appointment standards in its PCP Practitioner Agreement.
- Enhance monitoring and oversight of its delegates to ensure member letters include the required content.
- Remove language incorrectly stating that the member must follow a verbal appeal request with a written request.
- Update its policy to include that the coordinator will make reasonable efforts to notify the member of an extension.
- Develop a mechanism to compare disenrollment files to member-reported QOC concerns for tracking and trending.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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 recommended 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.

Assessment of NHP's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, NHP updated 15 critical member materials, developed and implemented a monitoring mechanism to ensure printed materials are sent to the member upon request within five business days, and updated EPSDT documents to include the correct *Bright Futures Guidelines* time frames for annual well visits and to enhance annual non-utilizer outreach to ensure it is timely and has a reasonable chance of reaching the member. HSAG recognizes that the informational and EPSDT document updates are likely to result in long-term improvements, and NHP's enhanced procedures to ensure timely and reasonable member outreach are likely to result in long-term improvement.

Validation of Network Adequacy

NHP: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- NHP met all minimum network requirements for General and Pediatric Psychiatrists and other Psychiatric Prescribers, as well as Pediatric Behavioral Health Practitioners across all contracted counties, in each county designation. NHP likewise met all minimum network requirements for General Behavioral Health Practitioners in all contracted urban and rural counties.

- NHP performed strongly in many other PH and BH provider categories, with access greater than 95 to 99 percent of the minimum network requirements across county designations. Such categories included Adult Primary Care Practitioners (MD, DO, NP, CNS), with greater than 99.9 percent access, and General SUD Treatment Practitioners, with greater than 99 percent access.
- NHP had match rates above 90 percent for seven out of 10 PDV indicators.

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 network requirements for numerous SUD Treatment Facilities ASAM LOCs across multiple contracted urban, rural, and frontier counties.
- NHP did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in the contracted urban county, in 66.7 percent of contracted rural counties, or in 83.3 percent of contracted frontier counties.
- Overall, 62.0 percent of NHP's providers could not be located in the online provider directory. Of the providers located in the directory, only 25.3 percent were found at the sampled location.
- NHP had a match rate of 83.7 percent for the street address indicator.
- At 41.3 percent, NHP had the lowest match rate for the telephone number indicator.

To address these opportunities for improvement, HSAG recommends NHP:

- Continue to conduct an in-depth review of provider categories for which NHP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, NHP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the NHP data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that NHP seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of NHP's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, NHP reported taking the following actions:

- In the FY 2023 Q2 Network Adequacy Report, the RAEs were no longer required to report the time and distance standards for the Gynecology OB/GYN (MD, DO, NP, CNS) and Gynecology OB/GYN (PA) provider types.
- NHP worked to enhance the network within the region, with a focus on using American Rescue Plan Act of 2021 (ARPA) funds available to NHP for High Intensity Outpatient Treatment Capacity Expansion to encourage providers to create or expand services within the region, particularly in rural and frontier counties.

Based on the above response, NHP worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-27 presents NHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-27—FY 2022–2023 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	100.0%	99.3%
Diagnosis Code	99.3%	97.8%	97.1%
Place of Service	NA	94.9%	99.3%
Service Category Modifier	NA	97.8%	99.3%
Units	NA	97.8%	98.5%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	97.8%	99.3%
Service End Date	100.0%	97.8%	99.3%
Population	NA	97.8%	99.3%
Duration	NA	95.6%	99.3%
Staff Requirement	NA	95.6%	99.3%

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

Table 4-28 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 4-28—FY 2022–2023 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%
Diagnosis Code	100.0%	100.0%	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	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	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 2022–2023, HSAG found the following strengths for NHP:

- NHP self-reported high overall accuracy, with 90 percent accuracy or above for all five inpatient services data elements, all 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that NHP's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with four of the five inpatient services data elements, nine of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in NHP's EDV results, NHP had an 80 percent agreement rate between NHP's reviewers and HSAG's reviewers for the *Place of Service* data element in psychotherapy services.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended NHP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of NHP's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

NHP reported completing a RAE 411 EDV training with its provider network prior to the start of the RAE 411 audit. The training included an overview of the audit and documentation tips for providers to be successful in the audit. NHP asked that each provider use the training as part of its own internal training to enhance documentation related to the audit. NHP offered training to providers who fell below 90 percent, or placed the provider on a corrective action. Additionally, NHP worked with a provider on a QUIP project, which focused on low-performing encounter service categories. The facility was provided

training and subsequent chart audits took place over three months to test the validity of the targeted intervention.

Based on NHP's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

NHP: Adult CAHPS

Table 4-29 shows the adult CAHPS results for NHP for FY 2021–2022 and FY 2022–2023.

Table 4-29—Adult CAHPS Top-Box Scores for NHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	57.6%+	58.9%
Rating of All Health Care	52.9%+	45.5%+
Rating of Personal Doctor	73.3%+	68.5%+
Rating of Specialist Seen Most Often	72.3%+	63.3%+
Getting Needed Care	81.7%+	83.9%+
Getting Care Quickly	80.6%+	80.3%+
How Well Doctors Communicate	92.8%+	91.0%+
Customer Service	82.7%+	94.8%+ ▲ ↑

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

NHP: Strengths

The following measure's FY 2022–2023 score for NHP was statistically significantly higher than the 2022 NCQA national average and FY 2021–2022 score:

- *Customer Service*

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

The following measures' FY 2022–2023 scores for NHP were lower, although not statistically significantly, than the 2022 NCQA national averages:

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

The following measures' FY 2022–2023 scores for NHP were lower, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

To address these low CAHPS scores, HSAG recommends NHP:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Consider any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with members.

NHP: Child CAHPS

Table 4-30 shows the child CAHPS results for NHP for FY 2021–2022 and FY 2022–2023.

Table 4-30—Child CAHPS Top-Box Scores for NHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	72.6%	70.9%
Rating of All Health Care	65.2%+	68.8%
Rating of Personal Doctor	79.4%	71.8%
Rating of Specialist Seen Most Often	68.2%+	76.7%+
Getting Needed Care	76.5%+	89.9%+ ▲
Getting Care Quickly	81.1%+	90.8%+
How Well Doctors Communicate	94.7%+	95.3%
Customer Service	82.1%+	96.3%+ ▲ ↑

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

NHP: Strengths

The following measure's FY 2022–2023 score for NHP was statistically significantly higher than the 2022 NCQA national average:

- *Customer Service*

The following measures' FY 2022–2023 scores for NHP were statistically significantly higher than the FY 2021–2022 scores:

- *Getting Needed Care*
- *Customer Service*

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

The following measures' FY 2022–2023 scores for NHP were lower, although not statistically significantly, than the 2022 NCQA national averages:

- *Rating of Health Plan*

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

The following measures' FY 2022–2023 scores for NHP were lower, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of Health Plan*
- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends NHP:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with parents/caretakers of child members.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, NHP reported engaging in the following QI initiatives:

- Created a CAHPS survey tip sheet in both English and Spanish, which explains what a CAHPS survey is and the importance of taking the CAHPS survey. NHP presented this tip sheet to participants of the QIC, the Member Services Subcommittee, and the Care Coordination meeting in January 2023. Additionally, this tip sheet was placed in the January 2023 edition of the provider newsletter and placed on NHP's website (see CAHPS Survey Information). The goal of creating and distributing this tip sheet is to encourage healthcare providers and member advocates to educate and promote the importance of completing the survey to their members.
- Continued initiatives to improve access to child and adolescent wellness care. Action lists from the Data Analytics Portal were sent so that practices may initiate outreach to members who have not received this valuable preventive care visit. Training was also provided on how to make these lists actionable during the First Friday Quality Forum.

Assessment of NHP's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that NHP addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with NHP.

Quality Improvement Plan

Table 4-31 presents NHP's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-31—Summary of NHP QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Place of Service	68%	100%	100%	100%

**Green shading indicates accuracy of 90 percent and higher.*

NHP: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- NHP reached 100 percent accuracy in the QUIP for the one data element, *Place of Service*, in the psychotherapy services claim type, which improved from 68 percent to 100 percent in month one and maintained 100 percent accuracy for months two and three.
- Key interventions throughout the QUIP included training for providers that involved audits to determine if the error rate was reduced. Training also focused on addressing the 411 audits as well as specific errors regarding *Place of Service*. Results showed significant improvements that demonstrated effectiveness and sustainability.

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

HSAG found the following opportunities for improvement:

- NHP reported low baseline accuracy results were due to its staff members' lack of awareness of the intricacies of the USCS Manual and how it applies within the pilot partner's EHR system.

To address these opportunities for improvement, HSAG recommends NHP:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

Due to successful results during the QUIP project, HSAG recommended that NHP continue focusing on training efforts.

Assessment of NHP's Approach to Addressing FY 2021–2022 QUIP Recommendations

NHP reported that its adopted training regarding USCS Manual requirements and best practice documentation was transferable across providers and data elements and has been successful. HSAG recognizes that this standardized training, paired with feedback, is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-32 displays the MHP Audit compliance scores for NHP for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-32—FY 2022–2023 MHP Audit Score for NHP

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
NHP	2	98%	Inpatient	93%	91%v
			Outpatient	86%	

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

NHP: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- NHP delegated UM activities to Beacon Health Options (Beacon) and followed policies and procedures regarding adequate monitoring and oversight of delegated activities.
- Beacon used nationally recognized UR criteria, including InterQual, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- NHP required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Additionally, Beacon reported that the last IRR testing occurred in summer of 2022, and all UM staff members exceeded the minimum score of 80 percent.

- In all cases reviewed, Beacon followed its policies and procedures related to which services require prior authorization. In most cases, Beacon notified providers of the denial determinations by telephone or email, and providers received a copy of the NABD within the required time frame.
- In all records reviewed, the denial determinations were made by a qualified clinician, and requesting providers were offered a peer-to-peer review.
- Most NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system. Additionally, all NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from NHP when filing, and access to pertinent records. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity.
- During the MHP interview, Beacon staff members reported that when a particular LOC is denied and a lower LOC is recommended, if the member has been receiving services and the denial is related to a concurrent request to continue services, care coordination staff members are part of the member's discharge planning process and would coordinate follow-up. If the member had not been receiving services and the denial was related to a new request, the NABD may refer the member to care coordination to find a provider or to contact NHP/Beacon to request care coordination services.

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

HSAG found the following opportunities for improvement:

- Notification to the providers and/or member regarding the denial determination within the required time frame was not demonstrated in multiple records reviewed.
- One NABD reviewed only stated the reason for the denial as not being a covered benefit and did not provide any other information or clearer context to the member regarding the service not meeting medical necessity.
- While the NABDs included the required content, many NABDs scored high reading grade levels using the Flesch-Kincaid readability test.
- Inpatient and residential SUD NABDs included the required ASAM language; however, applicable UM documents and policies and procedures did not outline the requirement for the NABDs to include ASAM language.

To address these opportunities for improvement, HSAG recommends NHP:

- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.
- Provide continuous and regular training for UM staff members to ensure that NABDs are clear in describing the reason(s) for the denial and are written at an easy-to-understand reading grade level. Additionally, should Beacon use any medical terminology, HSAG recommends including a plain language explanation next to any medical terminology.
- As a best practice, update applicable UM documents and policies and procedures to outline the required ASAM language within inpatient and residential SUD NABDs.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of NHP's Approach to Addressing FY 2021–2022 MHP Recommendations

NHP reported addressing HSAG's recommendations by:

- Providing additional training to UM staff members in June 2022 regarding documentation requirements for denial determinations, which include the UR criteria used and additional information needed within the NABD to help members better understand the denial determination.
- Conducting ongoing monitoring through quality peer and/or supervisor audits to assess compliance. If any deficiencies were observed, the affected staff member(s) received additional training to improve their understanding of the requirements.
- Clarifying Beacon's responsibility for coordinating the recommended alterative service(s) after a particular LOC is denied through the UM training. UM staff members were instructed to inform a member's care coordination team whenever an alternative service is recommended to reduce potential gaps in care, and care coordination referrals must be documented in the member's record.

NHP and Beacon still have the opportunity to address HSAG's recommendation of adding additional information to the reason and rationale for denial so that members may better understand the circumstances surrounding the denial of services and ensuring the NABDs are written at an easy-to-understand reading grade level. NHP's reported updates, which focused on training, documentation, communication, and auditing mechanisms, indicate improvement in some of Beacon's UM processes. NHP and Beacon should continue to address the recommendations made by HSAG and continue to make updates, conduct staff trainings, and monitor NABD language and content.

QOC Concern Audit

The QOC Concern Audit was not conducted with NHP in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended NHP:

- Implement ongoing staff training on the Colorado-specific QOC grievance process.
- Review and update applicable policies and process documents to:
  - Include the Potential Quality Issue (PQI) form and point system process.
  - Include a process for sending acknowledgement 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, HSAG recommended NHP 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.

Assessment of NHP's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

NHP reported addressing HSAG's recommendations by:

- Conducting investigations of potential QOC concerns/grievances through the Quality Management (QM) department and evaluating findings for appropriate follow-up, corrective action, and monitoring through the QOC Committee that meets once per month, at minimum.

- Offering the Adverse Incident reporting form digitally to providers at each quarterly training and informing providers of the reporting process at least twice per year through mass distribution email. Providers, NHP staff members, and/or other concerned parties can report QOC concern/grievance issues by submitting the Adverse Incident reporting form to the QM department.
- Updating policies and procedures and workflows to comply with contractual requirements.
- Providing acknowledgement and resolution letters to any party reporting a QOC concern/grievance issue.
- Sending the Department quarterly reports of founded QOC grievance cases and collaborating with the Department to determine the contractual requirements of investigating QOC concerns and QOC grievances for out-of-network and noncontracted provider complaints.
- Increasing tandem work with the grievance coordinator/OMFA to include, but not limited to, collaborating on the updated Department contractual changes for QOC grievance investigation requirements.
- Adding race, ethnicity, and disability status to NHP's internal QOC grievance tracking process and integrating with demographic data, when available.

HSAG anticipates NHP's response to the recommendations are likely to improve overall processes and compliance with contractual requirements. NHP should continue addressing the recommendations made by HSAG and prepare for guidance from the Department for upcoming contractual changes and requirements.

EPSDT Audit

Table 4-33 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-33—FY 2022–2023 EPSDT Audit Findings for NHP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	75%	33%	63%
Post-Denial Record Review	83%	80%	86%

NHP: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- Following a denial of service, NHP's delegated CM staff members followed up with the member to ensure the member's needs were supported through care coordination.
- NHP hosted Provider Roundtables (two during the review period) and RAE 101 EPSDT Early Childhood Mental Health training in September 2022. The NHP website included information regarding EPSDT tip sheets, Bright Futures, provider alerts for training opportunities, and details regarding NHP's QUIP and multi-system involved populations from the review period.
- NHP submitted seven trainings for internal staff members during the review period including: care coordination, provider relations, call center, member engagement, and trainings provided in collaboration with external partners at roundtable events.
- Policies, procedures, and quarterly reports indicated IVR and texting scripts were used. Quarterly reports stated that NHP initiated between one and 1.6 average attempts per member, citing an 87 percent completion rate in FY 2021–2022 Q4. Furthermore, all members in the non-utilizer sample received attempts to outreach.
- NHP had a process for ongoing outreach to members who opted to receive texts. NHP had multiple campaign types, such as well care, developmental messages, dental care, flu shot, coronavirus disease 2019 (COVID-19) messaging, stress relief, and a satisfaction survey campaign.
- Outreach reports indicated that by the end of the review period, Carelon had implemented birthday mailers at a reported 100 percent outreach success rate.
- The sample denial records demonstrated that NHP sent all 15 NABDs. Notably, NHP was one of the few MCEs in which most NABDs included specific next steps for the member and recommended alternative LOCs.
- NHP described oversight of care coordination activities through the Health Cloud (SalesForce) system where NHP staff members were able to login and see high-level service and care coordination requests. NHP submitted additional supporting evidence of care coordination for 14 out of the 15 denial sample records, either through the use of a delegated care coordination entity or through NHP outreach and follow-up, which was documented in the Health Cloud system.

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

HSAG found the following opportunities for improvement:

- Multiple cases indicated members only received one IVR outreach attempt; however, all of these cases were considered successful since NHP left a voicemail, but only one case resulted in a member picking up the phone and engaging in a live phone call.
- NHP's submitted policies and procedures did not detail how NHP worked with the Department to request EPSDT services or submit additional documentation as evidence of how NHP advises members of benefits available under the State plan but not covered by the RAE.
- During the interview, NHP staff members noted that North Colorado Health Alliance (NCHA) is taking over the Creative Solutions meeting.

To address these opportunities for improvement, HSAG recommends NHP:

- Discuss with the Department whether voicemails may be considered completed outreach.
- Develop a desktop procedure that outlines how NHP works with the Department to obtain EPSDT services for members, when necessary.
- Include information and specific responsibilities regarding NCHA's role in Creative Solutions meetings in the desktop procedure.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- Record review of denial determinations showed NHP's documentation of medical necessity criteria to be limited. Similarly, the Medical Necessity Determination and Medical Necessity Determination Timelines policies contained language that could be limiting to the scope of the review.
- Denial records reviewed included only brief documentation of phone conversations with providers and UM notes were limited overall. Carelon staff members noted updates to expand UM documentation procedures that occurred during the summer of 2022; however, this was only mentioned in terms of SUD denial review documentation and not applied for other types of UM reviews.
- Documentation provided by NHP indicated "no risk assessment" in the case files for the non-utilizer sample population, and HSAG could not find evidence of implementation to demonstrate NHP followed up with members to offer services or support for SHCN.
- NHP did not use mailings when electronic attempts at outreach failed.

Although these findings did not lead to recommendations, HSAG informed NHP of these findings within the report. NHP should work on addressing these findings to improve processes, procedures, and communication with the Department.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-34 presents the number of cases in the sample that HSAG reviewed for NHP and the percentage of cases in which HSAG reviewers agreed with NHP's denial determination. NHP reported that 20 of the 31 sample cases were administrative (65 percent), and 11 out of the 31 cases were based on medical necessity (35 percent). Within the subset of administrative denials, five of the administrative denial cases were not true denials, but rather system-generated denials to indicate the end of an authorization period. Those five cases were excluded from the sample.

Table 4-34—NHP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
NHP	31	26[1]	100%
[1] Due to five samples being not applicable, the total applicable sample is 26.			

NHP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for NHP:

- NHP used a two-step process for reviewing initial and continuing requests for services. All first-level reviewers were registered nurses (RNs), licensed professional counselors (LPCs), licensed addiction counselors, or had a master of social work degree. In all cases reviewed, when the first-level reviewer recommended a denial determination, the case was referred to a doctor of medicine to make the final decision.
- In all cases reviewed, the HSAG clinical reviewer agreed with the denial determination made by NHP.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Due to SOPs within Beacon's UR systems, many of the denials in the review sample were triggered at the end of an authorization period in which the provider had not requested continued services. Federal regulations do not require a NABD be sent at the end of an authorization period. However, Beacon staff members stated that due to system constraints, a denial needed to be recorded in the system to "close" the record. These administrative denials were recorded despite no service authorization requests being received from the providers. Beacon's UR processes impacted the denial sample for NHP, as administrative denials were disproportionately larger than almost any other MCE in the sample.
- Several of the Beacon files lacked clinical documentation of the authorization request and included only minimal notes from telephone calls. Staff members indicated that this was standard practice for the majority of FY 2021–2022.
- Out of the 26 applicable cases where members should have received a NABD, only 11 cases included documentation of NHP mailing the member the notice. Many files included documentation stating that the provider would inform the member of the denial; however, there was no way for HSAG to verify if the notification occurred or if the notification was provided in writing by the provider. Out of the 11 notices documented, 10 were sent within the required 24-hour or 72-hour time frame. The one untimely notice was sent within five days.

To address these opportunities for improvement, HSAG recommends NHP:

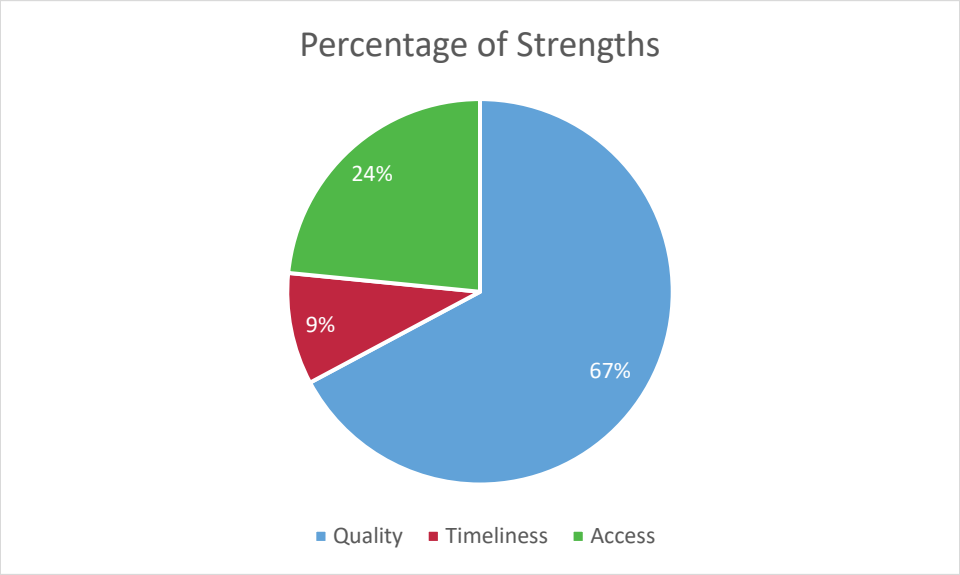
- Perform immediate updates to the system to ensure that denials are not recorded when no request for services has been submitted.
- Update its policies, procedures, and processes to ensure that sufficient clinical documentation is received and included in each service authorization file to support the authorization approval or denial.
- Update policies, procedures, and processes to ensure that members receive the correct NABD template.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

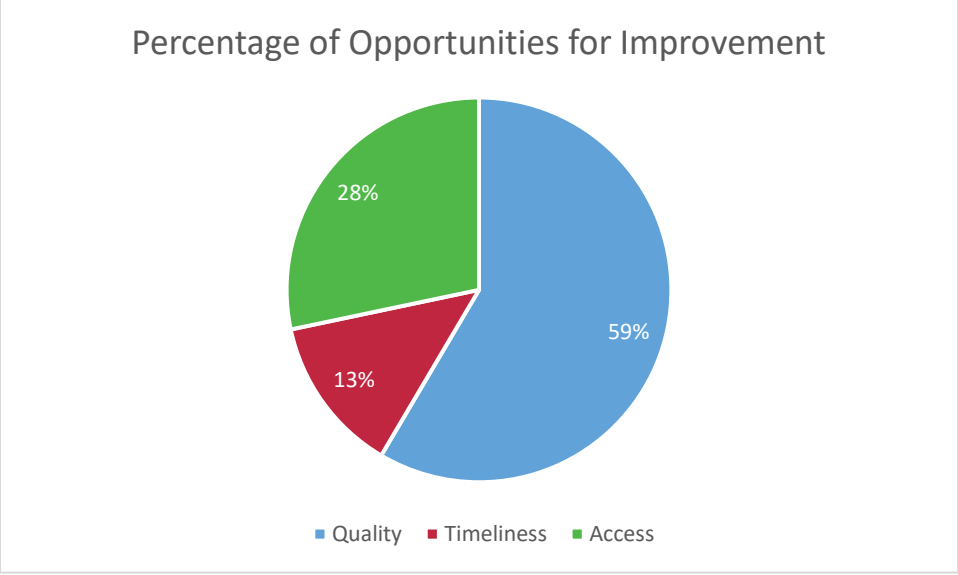
Region 3—Colorado Access

Figure 4-5—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 4-6—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, timeliness, and accessibility of care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, 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 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, COA Region 3 established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-35 and Table 4-36 summarize COA Region 3's PIP activities that were completed and validated in FY 2020–2021. Table 4-35 provides the SMART Aim statements that COA Region 3 defined for the two PIP outcome measures in Module 1.

Table 4-35—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 4-36 summarizes the preliminary key drivers and potential interventions COA Region 3 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-36—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.

Table 4-37 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-37—Intervention Testing Plan 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 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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
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)

FY 2022–2023 PIP Activities

In FY 2022–2023, COA Region 3 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed COA Region 3's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated COA Region 3's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for COA Region 3's PIP are presented in Table 4-38. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-38—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens in well visits among members ages 12 years and older who receive care at Every Child Pediatrics and Peak Vista Community Health Centers.	86.84%	88.72%	90.72%	*Yes*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of *Follow-Up After a Positive Depression Screen* visits completed among members ages 12 years and older within 30 days of a positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers.	56.81%	65.76%	58.55%	*No*

To guide the project, COA Region 3 established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during a well visit at Every Child Pediatrics and Peak Vista Community Health Centers from 86.84 percent to 88.72 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 56.81 percent to 65.76 percent, through the SMART Aim end date of June 30, 2022. COA Region 3's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 90.72 percent, representing a statistically significant increase of 3.88 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 58.55 percent, representing an improvement of 1.74 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, COA Region 3 completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-39 summarizes COA Region 3's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-39—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Peak Vista Community Health Centers electronic health record (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, provide provider education and best practices toolkit for depression screening, and provide follow-up services and workflows.	*Programmatic* improvement for *Depression Screening* and *Follow-Up After a Positive Depression Screen*	Adapted
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.	*Evaluation results were inconclusive*	Adopted
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.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

COA Region 3: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- COA Region 3 developed and carried out a methodologically sound improvement project.
- COA Region 3 accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure and non-statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure.

- COA Region 3's intervention testing results demonstrated clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions. 

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

Based on PIP validation activities conducted in FY 2022–2023, COA Region 3's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of COA Region 3's PIP, HSAG recommended:

- 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.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 PIP Recommendations

COA Region 3 successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-40 shows the performance measure results for COA Region 3 for MY 2020 through MY 2022.

Table 4-40—Performance Measure Results for COA Region 3

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	38.84%	45.09%	51.53%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	64.71%	56.76%	46.84%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	31.97%	30.50%	26.30%	48.22%
Follow-Up After a Positive Depression Screen	41.50%	43.47%	46.66%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	12.17%	15.41%	14.63%	30.56%

COA Region 3: Strengths

The following performance measure rates for MY 2022 increased from the previous year for COA Region 3:

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

Additionally, the following performance measure rate for MY 2022 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*

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:

- *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:

- Further expand on the performance-based dashboard to include thresholds to identify shifts in performance rates.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, COA Region 3 reported implementing the following:

- Performance metric dashboards used for real-time data trend monitoring, tracking, and evaluating of programming and interventions tied to performance metrics, for the internal and external reporting with stakeholders, and for communicating data during routine meetings and collaboration with the Department.
- A Metric Steward Program in July 2022.
- Collaboration with providers on best practices and specific interventions aimed at improving performance metrics such as the *Follow-Up After a Positive Depression Screen* metric.
- A series of workgroups with a select cohort of providers to dive into these performance metrics. This was designed for providers to collaborate and share best practices to drive performance and inform opportunities to scale interventions across the network.

HSAG recognizes that the implementation of the dashboard and the provider workgroup are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 3 Overall Evaluation

Table 4-41 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-41—Summary of COA Region 3 Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	29	3	0	0	91%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	35	35	33	2	0	0	94%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**81**	**5**	**0**	**0**	**94%***

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

Table 4-42 presents the compliance scores for record reviews conducted for COA Region 3 during FY 2022–2023.

Table 4-42—Summary of COA Region 3 Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	73	67	6	27	92%
Grievances	60	56	55	1	4	98%
Appeals	60	54	54	0	6	100%
Totals	**220**	**183**	**176**	**7**	**37**	**96%***

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

COA Region 3: Trended Performance for Compliance With Regulations

Table 4-43 presents, for all standards, the overall percentage of compliance score for COA Region 3 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-43—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; 2022–2023)	**80%**	**91%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**100%**	**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 VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	**80%**	**94%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, each standard reviewed for COA Region 3 demonstrated consistent high-achieving scores from the previous review cycle, two of which improved and one of which maintained 100 percent compliance, indicating a strong understanding of most federal and State regulations.

COA Region 3: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- Policies, procedures, and reporting documents outlined a comprehensive UM approach to review and authorize covered services using medical necessity and InterQual criteria in compliance with regulatory guidelines. UM staff members participated in annual IRR testing to ensure criteria are applied consistently.
- The provider manual and website included accurate information regarding time and distance standards, and provider network and quality department staff members also outreached providers to inform them of timely appointment standards prior to conducting monitoring activities such as secret shopper. CAPs for providers who failed to comply with timely appointment standards were individualized based on the type of noncompliance documented and have shifted to an "opportunity" lens.
- Cultural competency efforts have been a focus in the organization, and staff members reported the addition of a vice president of diversity, equity, and inclusion (DEI) and an expanded team of DEI "consultants." Targeted outreach and engagement programs described during the interview included the following member groups: Latinx, homeless, refugee, and members recently released from prison. These member populations were noted as top priorities during the CY 2022 review period related to cultural competency efforts.
- Staff members described how they inform members of their rights if a member contacts COA Region 3 to file a grievance and the ways the member or the member's authorized representative can submit a grievance. The member can submit a grievance by phone, email, online, or fax to customer service, care managers, or other staff members, and all staff members are trained to submit grievances to the grievance team.
- When a member filed an appeal, in addition to sending a written acknowledgement letter, the COA Region 3 appeals coordinator verbally contacted the member to ensure that the member, or the member's representative, was aware that he or she has the right to submit documents, records, and other information, and that all comments will be considered by the decision maker without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to COA Region 3's system with no restriction.

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

HSAG found the following opportunities for improvement:

- NABDs included clinical terminology that may not be easy for the member to understand.
- COA Region 3 did not mail an NABD to the member in one case.
- COA Region 3 did not make the denial decision or send the NABD within the 72-hour expedited time frame in one case.
- Geoaccess compliance reports, quarterly *Network Reports*, and the *Network Adequacy Plan* each included details of a few gaps in COA Region 3's provider network.
- One out of the 10 sample grievance records did not comply with the grievance acknowledgement letter time frame set forth by the State.
- An old policy inaccurately stated that the member must follow an oral request of an appeal in writing.

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

- Update its procedures to further delineate provider claims issues, which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service in a timely manner.
- Include a plain language explanation next to any clinical terminology in member communications.
- Enhance its monitoring procedures to ensure that member notices, such as NABDs, are sent to the member in a timely manner.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.1, 3.3, 3.5, 3.7, 3.2 WM, and 3.7 WM), psychiatric hospitals, and psychiatric units in acute care hospitals.
- Enhance its monitoring system to ensure that grievance acknowledgement letters are sent in a timely manner.
- Remove any statement that requires the member to follow an oral appeal request with a written appeal request.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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 updated federal language "or 30 days prior to the effective date of the termination" when notifying the member of a provider termination.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, COA Region 3 updated policies and procedures to include clarification that a member may submit a complaint and it will be resolved within the state-required time frame and the policy language, language regarding the time frame to send the member a provider termination notice, and language in the *New Member Booklet* to inform members of their right to receive documents upon request within five business days. HSAG recognizes that policy and member informational document updates are likely to result in long-term improvements.

Validation of Network Adequacy

COA Region 3: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- COA Region 3 met all minimum network requirements for General and Pediatric Behavioral Health Practitioners, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties, across urbanities. 
- COA Region 3 performed well in the provider categories of Adult, Family, and Pediatric, and Primary Care (for MD, DO, NP, CNS, and PA provider types), meeting the minimum network requirements in three of the four contracted counties. In the county for which COA Region 3 did not meet the minimum network requirements for these provider categories, access was greater than 90 percent of the minimum network requirements. 
- Based on the PDV results, strengths were not identified for COA Region 3.

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 network requirements for any SUD Treatment Facilities ASAM LOCs in the contracted counties. Several ASAM LOCs had higher rates of access. For example, SUD Treatment Facilities—ASAM LOC 3.1 demonstrated 98 to 99 percent access across counties; however, ASAM LOCs 3.3 and 3.7 had consistently low percentages of access.
- COA Region 3 did not meet the minimum network requirements for General or Pediatric SUD Treatment Practitioners in 75 percent of contracted counties.
- Overall, 51.8 percent of COA Region 3's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 39.4 percent were found at the sampled location. While COA Region 3 noted that providers participating with a CMHC or other treatment center are not listed individually in the online provider directory, these providers are listed individually in COA Region 3's provider data, resulting in a high rate of mismatched data for this indicator.
- COA Region 3 had a match rate of 59.9 percent for the telephone number indicator.
- At only 1.2 percent, COA Region 3 had the lowest match rate for the accepting new patients indicator. However, new patient acceptance information is missing from the COA online provider directory.

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

- Continue to conduct an in-depth review of provider categories for which COA Region 3 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, COA Region 3 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure COA Region 3's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that COA Region 3 seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, COA Region 3 reported taking the following actions:

- COA Region 3 continued to seek opportunities to expand the care network, including Gynecology (Mid-Level practitioners) and Pediatric Primary Care (Mid-Level practitioners) network categories, to ensure adequate network providers and access to care. Building on the foundation of the existing network, COA Region 3 continued to use various resources to further target potential additions and grow the network of providers.
- COA Region 3 remained dedicated to contracting with every willing state-validated provider to become part of the COA Region 3 network, regardless of their location, provided they meet the credentialing and contracting criteria.

Based on the above response, COA Region 3 worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-44 presents COA Region 3's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-44—FY 2022–2023 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	89.8%	94.9%
Diagnosis Code	97.1%	95.6%	95.6%
Place of Service	NA	86.1%	97.1%
Service Category Modifier	NA	89.8%	94.9%
Units	NA	98.5%	97.1%
Revenue Code	97.8%	NA	NA
Discharge Status	90.5%	NA	NA
Service Start Date	93.4%	99.3%	97.1%
Service End Date	97.1%	98.5%	97.1%
Population	NA	99.3%	97.1%
Duration	NA	94.9%	97.1%
Staff Requirement	NA	97.1%	97.1%

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

Table 4-45 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 4-45—FY 2022–2023 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%	100.0%
Diagnosis Code	90.0%	100.0%	100.0%
Place of Service	NA	80.0%	100.0%
Service Category Modifier	NA	100.0%	90.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	90.0%	100.0%	100.0%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
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.

COA Region 3: Strengths

Based on RAE 411 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- COA Region 3 self-reported high overall accuracy, with 90 percent accuracy or above for all five inpatient services data elements, seven of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- 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 three of the five inpatient services data elements, nine of the 10 psychotherapy services data elements, and nine 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:

- While the over-read results suggest confidence in COA Region 3's EDV results, COA Region 3's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with an 86.1 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

COA Region 3 reported implementing CAPs for providers that score below 95 percent and have a sufficient number of records to assess general documentation practices. The CAPs may include requirements such as root cause analyses, retraining staff, systems enhancements, and/or provider re-audits. COA Region 3 reported offering providers education and training on quality documentation in collaboration with its Quality Department, Practice Support Team, and provider network managers.

Based on COA Region 3's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

COA Region 3: Adult CAHPS

Table 4-46 shows the adult CAHPS results for COA Region 3 for FY 2021–2022 and FY 2022–2023.

Table 4-46—Adult CAHPS Top-Box Scores for COA Region 3

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	54.0%	54.9%
Rating of All Health Care	60.5%+	48.2%
Rating of Personal Doctor	61.7%	62.1%
Rating of Specialist Seen Most Often	69.0%+	63.2%+
Getting Needed Care	77.8%+	72.1%+ ↓
Getting Care Quickly	77.9%+	71.9%+
How Well Doctors Communicate	88.8%+	90.2%+
Customer Service	82.2%+	81.7%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

COA Region 3: Strengths

The following measures' FY 2022–2023 scores for COA Region 3 were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measure's FY 2022–2023 score for COA Region 3 was statistically significantly lower than the 2022 NCQA national average:

- *Getting Needed Care*

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

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality, timeliness, and accessibility of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

COA Region 3: Child CAHPS

Table 4-47 shows the child CAHPS results for COA Region 3 for FY 2021–2022 and FY 2022–2023.

Table 4-47—Child CAHPS Top-Box Scores for COA Region 3

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	74.2%	66.5%
Rating of All Health Care	64.9%	65.3%
Rating of Personal Doctor	72.1%	71.7%
Rating of Specialist Seen Most Often	75.0%+	61.3%+
Getting Needed Care	83.6%+	75.5% ↓
Getting Care Quickly	86.9%+	83.9%
How Well Doctors Communicate	91.6%	92.7%
Customer Service	88.7%+	88.1%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

COA Region 3: Strengths

The following measure's FY 2022–2023 score for COA Region 3 was higher, although not statistically significantly, than the 2022 NCQA national average:

- *Customer Service*

The following measures' FY 2022–2023 scores for COA Region 3 were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measure's FY 2022–2023 score for COA Region 3 was statistically significantly lower than the 2022 NCQA national average:

- *Getting Needed Care*

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

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for parents/caretakers of child members.
- Direct parents/caretakers to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, COA Region 3 reported engaging in the following QI initiatives:

- Collected and analyzed data from a fourth iteration of a member satisfaction survey administered in June 2022, and administered a fifth member satisfaction survey, which is currently being analyzed, in March 2023, to better understand member experience and perceptions of care. The former survey included questions that focus on scheduling, appointment access, and what COA Region 3 could improve for members. The latter survey included survey questions that explored how members identify racially, culturally, and ethnically; how that identification impacts their healthcare experience; and how COA Region 3 can improve the member experience.
- Developed and implemented a CAHPS communication plan in 2023. Information describing what the CAHPS survey is, the timeline for data collection, and the value it brings to members, providers, and the Health First Colorado system was communicated in the following venues: 1) provider manual, 2) quarterly provider newsletter, 3) internal COA Region 3 employee newsletter, 4) member newsletter, and 5) COA Region 3 social media platforms.
- Continued the COA Region 3 customer service quality monitoring program in 2023, including continuous monitoring of NPS scores, customer service representative (CSR) quality audits, ongoing collaboration, and continued internal member satisfaction survey iteration and administration. If trends are identified, additional training is provided to relevant departments.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that COA Region 3 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with COA Region 3.

Quality Improvement Plan

Table 4-48 presents COA Region 3's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-48—Summary of COA Region 3 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Diagnosis Code	84%	100%	100%	100%
Psychotherapy Services	Procedure Code	75%	100%	50%	50%
	Diagnosis Code	78%	50%	100%	100%
	Place of Service	77%	0%	50%	100%
	Service Category Modifier	75%	100%	50%	50%
	Units	88%	100%	100%	100%
	Service Start Date	88%	100%	100%	100%
	Service End Date	88%	100%	100%	100%
	Population	88%	100%	100%	100%
	Duration	81%	100%	50%	100%
	Staff Requirement	83%	100%	100%	100%

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

COA Region 3: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- COA Region 3 reached 100 percent accuracy for nine out of 11 data elements. Most notably, the one psychotherapy services claim type, *Place of Service*, decreased from 77 percent to 50 percent in month one, however, improved in month two to 100 percent and maintained 100 percent accuracy for month three.

- Key interventions for the QUIP included issuing CAPs to the pilot partners, directing additional training and education on the topic.

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

HSAG found the following opportunities for improvement:

- Two data elements (*Procedure Code* and *Service Category Modifier*) for the psychotherapy services claim type had inconsistent results that ultimately did not improve above the 90 percent accuracy threshold.
- COA Region 3 reported that the pilot partner had low accuracy results because the diagnosis listed on the claim did not match the diagnosis on the service documentation, provider signatures and duration were not included in service documentation, and service documentation did not match the place of service listed on the claim.

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

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that COA Region 3 maintain oversight of encounter data and communication with providers to ensure that accuracy rates remain above the 90 percent threshold, as well as provide targeted training and/or outreach to address specific areas of non-accuracy (e.g. *Place of Service* requirements).

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 QUIP Recommendations

COA Region 3 reported that it implemented CAPs for providers that scored below 95 percent accuracy (if the provider had a sufficient number of records to assess). The CAPs consisted of root cause analyses, retraining staff members, systems enhancements, and provider audits. Education was offered to providers regarding quality documentation, and COA Region 3 continues to maintain a claims audit program. HSAG recognizes that training and consistent auditing, paired with feedback, are likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-49 displays the MHP Audit compliance scores for COA Region 3 for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-49—FY 2022–2023 MHP Audit Score for COA Region 3

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
COA	3	100%	Inpatient	98%	96%v
			Outpatient	94%	

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

COA Region 3: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- COA Region 3 used nationally recognized UR criteria, including InterQual, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- COA Region 3 required UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- All records reviewed demonstrated COA Region 3 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.
- COA Region 3 made the denial determinations within the required time frame, and providers were notified of the denial determinations through telephone or secure email and received a copy of the NABD for all records reviewed.
- In all records reviewed, the denial determination was made by a qualified clinician and contained evidence that the peer-to-peer review was offered to the requesting provider.
- Most records reviewed demonstrated that the NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
- All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA Region 3 when filing, access to pertinent records, and the reason for the denial.

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

HSAG found the following opportunities for improvement:

- In one instance, COA Region 3 did not send an NABD to the member within the required time frame.
- One case review did not contain documentation to indicate that COA Region 3 conducted additional outreach to the requesting provider for more information to determine medical necessity.
- The NABDs reviewed did not always score at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.

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

- Enhance monitoring mechanisms to ensure the member is informed of the denial within the required time frame.
- Enhance monitoring procedures to ensure additional outreach occurs with the requesting provider when adequate documentation is not received.
- Conduct periodic staff training and monthly record audits to ensure that NABDs are at an easy-to-understand reading grade level.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 3 found to be present or not present related to the criteria).

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended COA Region 3:

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

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 MHP Recommendations

COA Region 3 reported addressing HSAG's recommendations by:

- Monitoring denial cases to ensure that NABDs are sent to members in a timely manner.
- Conducting staff member training and internal audits to confirm complete documentation of the peer-to-peer review process.

COA Region 3 still has the opportunity to address HSAG's recommendation of including the specific name of the criteria used to make the denial determination in the NABD. COA Region 3's reported updates will most likely demonstrate improvement to overall UM processes. COA Region 3 should continue to address the recommendation made by HSAG in an effort to help the member better understand the circumstances and criteria used to make the denial determination, ensure timeliness regarding sending the NABD to the member, and achieve MHP compliance.

QOC Concern Audit

The QOC Concern Audit was not conducted with COA Region 3 in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended COA Region 3:

- Continue ongoing staff training on the Colorado-specific QOC grievance 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, HSAG recommended COA Region 3 implement a process for QOC concern 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 QOC concerns received, according to contractual requirements. Currently, COA Region 3 is reporting this information to the Department annually.

Assessment of COA Region 3's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

COA Region 3 reported addressing HSAG's recommendations by:

- Developing a QOC training for internal staff members which outlines obligations to report QOCs and the reporting process. COA Region 3 incorporated the training into the care manager learning pathway, which was completed by all COA Region 3 CM staff members in January 2023 and is ongoing for new hires. COA Region 3 reported that it will continue to update the QOC training to reflect contract changes.
- Continuing tandem work between the quality and grievance teams to identify grievances that meet QOC thresholds to ensure timely investigation.

- Reporting QOCs to the Department according to contractually outlined requirements. COA Region 3 stated that it will report QOCs to the Department more regularly based on updates to contractually defined QOC reporting requirements.

HSAG anticipates COA Region 3's response to the recommendations are likely to improve overall processes and compliance with contractual requirements. COA Region 3 should continue to address the recommendations made by HSAG and continue to make updates based on guidance from the Department for upcoming contractual changes and reporting requirements.

EPSDT Audit

Table 4-50 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-50—FY 2022–2023 EPSDT Audit Findings for COA Region 3

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	50%	69%
Post-Denial Record Review	92%	50%	73%

COA Region 3: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- Policies, procedures, documentation, and interviews with staff members confirmed that COA Region 3 takes the full definition of "EPSDT medical necessity" into consideration. UM staff members described reviewing any collateral clinical documentation including the provider request, CM notes, InterQual, and consulting with the medical director before making any denial or partial denial decisions. Additionally, COA Region 3's documentation demonstrated a strong process for UM reviewers to consider medical necessity.
- Staff members described specialty UM reviewers, such as LPC, all of whom had been trained to follow the high needs pediatric workflow and how to coordinate with the Department regarding EPSDT service needs.
- COA Region 3's website included information about: maternal and child health; public health, mental health, and education programs; social services programs; Women, Infants and Children (WIC) supplemental food program; Supplemental Nutrition Assistance Program (SNAP); Nurse

Family Partnership (NFP); home visit programs; childcare programs; and cash assistance programs.

- COA Region 3 distributed updated EPSDT policies, procedures, and resources through the monthly provider newsletter, *The Navigator*. COA Region 3 focused on maternal health programming during the FY 2021–2022 review period, specifically the Text4Baby and Healthy Mothers, Healthy Babies campaigns.
- Staff members were trained on EPSDT benefits using Department-approved resources.
- Assessments submitted by COA Region 3 included aspects of EPSDT supports such as determining if the member needs help with transportation, food, housing, WIC, employment, supplies, financial referrals, etc.
- All 15 members within the non-utilizer sample received at least one outreach attempt during the review period.
- Many sample denial cases reviewed indicated that COA Region 3 assessed whether the service would assist the member in maintaining their current level of function or ameliorate the loss of functioning, support the member's long-term needs, and other needs.

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

HSAG found the following opportunities for improvement:

- COA Region 3's UM EPSDT policy outlined that CM would assist with scheduling and transportation, if requested by the member/family; however, none of the NABDs in COA Region 3's sample included specific next steps for the member or offered assistance with scheduling appointments and transportation. Assistance offered, if any, would occur when the care manager reached out to the member or parents/guardians.
- COA Region 3's policy outlined that the denial notification sent to the requesting provider includes additional information to encourage the provider to seek next steps, ensuring the provider requests the service from the correct place.

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

- Ensure its CM staff members proactively offer assistance with scheduling appointments and transportation if the need is relevant to the member's situation. Furthermore, COA Region 3 may consider the addition of an EPSDT informational flyer in applicable NABD mailings to enhance member/family awareness of available services. Additionally, HSAG suggests the addition of member-specific assistance, next steps, and offering transportation when applicable to the member's situation.

- Add additional outreach in the form of a phone call to the requesting provider before or after the issuance of the notice of denial.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- The IVR enrollment EPSDT message was robust with a great deal of information; however, the full narrative was only provided if the member answered the call and pushed the right number to authenticate that the member had been reached.
- COA Region 3 submitted multiple assessments that would be used to follow up with members that indicated SHCN; however, HSAG could not find evidence of implementation to demonstrate COA Region 3 followed up to offer services or support for SHCN as there were no risks assessments for the sample members.
- COA Region 3's Q4 FY 2021–2022 EPSDT Outreach Report indicated a 68 percent success rate but stated that, since COA Region 3 used a nonprofit mail rate, true outreach success rates were unable to be determined; therefore, letter campaigns were not assessed for success rate within the report.
- Although reaching an answering machine was considered a successful outreach by COA Region 3, the full message with EPSDT and benefit information was not left via voicemail.
- In one case, COA Region 3 did not use InterQual criteria, and there was limited documentation regarding medical necessity and how the staff member considered EPSDT when making the denial determination.
- Out of the applicable denial cases reviewed for COA Region 3, only some denial cases regarding noncovered diagnoses or services the MCE does not cover demonstrated evidence that COA Region 3 would work with the requesting provider.
- Multiple cases reviewed indicated that no care coordination was offered or was not offered around the time frame of the denial.

Although these findings did not lead to recommendations, HSAG informed COA Region 3 of these findings within the report. COA Region 3 should work on addressing these findings to improve processes and procedures.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-51 presents the number of cases in the sample that HSAG reviewed for COA Region 3 and the percentage of cases in which HSAG reviewers agreed with COA Region 3's denial determination.

Table 4-51—COA Region 3 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
COA Region 3	48	48	100%

COA Region 3: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 3:

- HSAG reviewers agreed with all COA Region 3 denial decisions.
- In all 48 cases reviewed, documentation showed that COA Region 3 notified providers by various methods of communication such as live call, voicemail, email, or the provider's preferred contact method within the required time frame.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Of the 48 cases reviewed, five did not include documentation of a member's NABD.
- Of the 43 NABD letters sent to members, 80 percent contained the required elements. The required elements missing information from the letters were the medical necessity criteria used to make the denial determination and description of each ASAM dimension.

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

- Update policies, procedures, and processes to ensure that members are notified of the denial determination and within the required time frame.

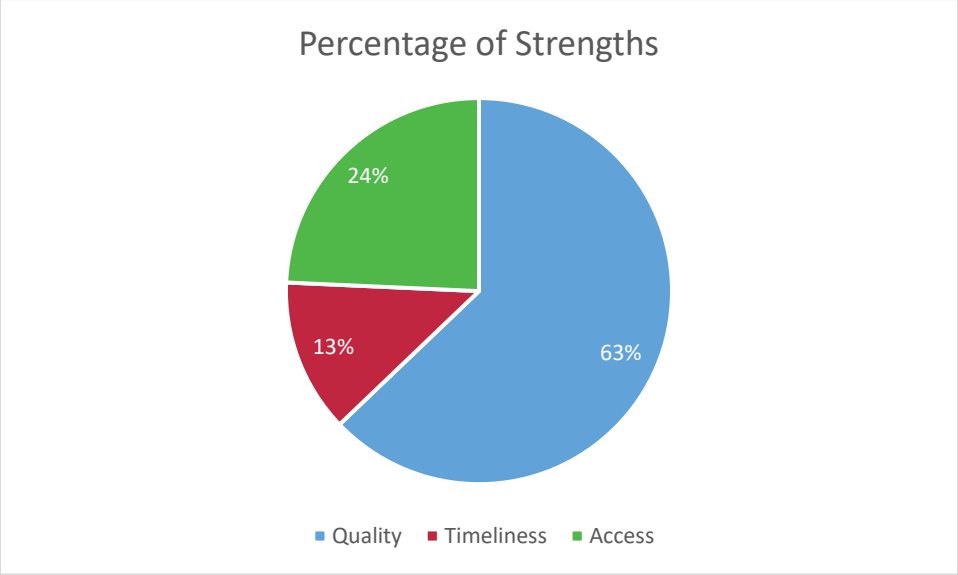
- Develop and use a NABD template to ensure that member communications regarding adverse benefit determinations include the full meaning of an acronym the first time it is used (e.g., substance use disorder [SUD], intensive outpatient [IOP], and American Society of Addiction Medicine [ASAM]) and to ensure that each of the required categories of information are included in the letter.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

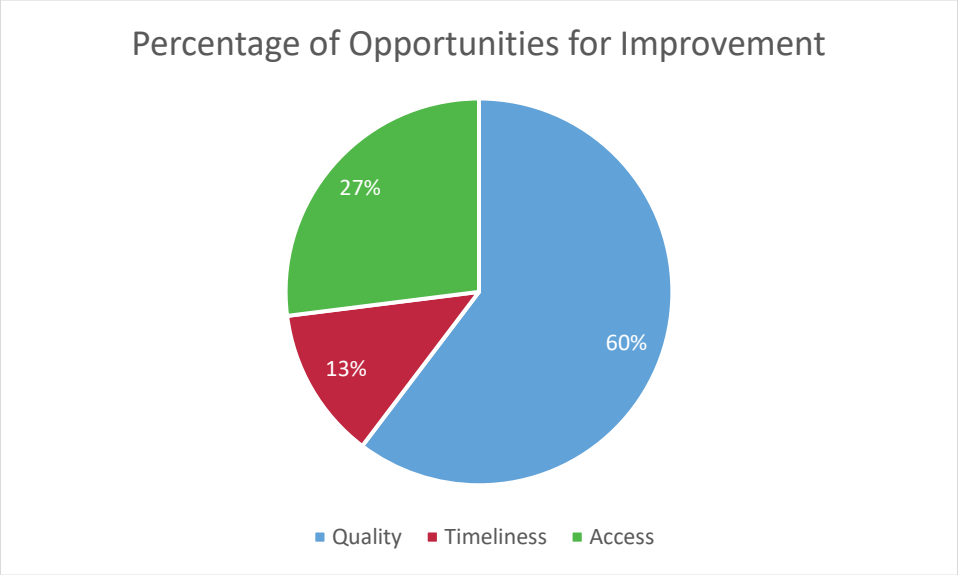
Region 4—Health Colorado, Inc.

Figure 4-7—Percentage of Strengths by Care Domain for HCI*



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

Figure 4-8—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, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, HCI continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, HCI established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-52 and Table 4-53 summarize HCI's PIP activities that were completed and validated in FY 2020–2021. Table 4-52 provides the SMART Aim statements that HCI defined for the two PIP outcome measures in Module 1.

Table 4-52—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 4-53 summarizes the preliminary key drivers and potential interventions HCI identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-53—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.

Table 4-54 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-54—Intervention Testing Plan 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*

FY 2022–2023 PIP Activities

In FY 2022–2023, HCI continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed HCI's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated HCI's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for HCI's PIP are presented in Table 4-55. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-55—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older.	11.21%	15.00%	10.10%	No
Follow-Up After a Positive Depression Screen				
The percentage of behavioral health (BH) follow-ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older.	25.15%	30.00%	58.20%	Yes

To guide the project, HCI established goals of increasing the percentage of members 12 years of age and older, attributed to Valley-Wide Health Systems, who received a depression screening during a well visit, from 11.21 percent to 15.00 percent, and increasing the percentage of those members who received BH services within 30 days of screening positive for depression from 25.15 percent to 30.00 percent, through the SMART Aim end date of June 30, 2022. HCI's reported SMART Aim measure results for the *Depression Screening* measure demonstrated that the SMART Aim goal was not achieved; the highest rate achieved, 10.10 percent, represented a decline from the baseline rate. The reported results for the *Follow-Up After a Positive Depression Screen* measure demonstrated that the SMART Aim goal was exceeded, and the highest rate achieved, 58.20 percent, represented a statistically significant increase of 33.05 percentage points above the baseline rate.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, HCI completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-56 summarizes HCI's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-56—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Staff feedback on depression screening performance and education on depression screening procedures	Significant *programmatic* improvement for *Depression Screening*	Abandoned
Provide training to coding auditors on the correct criteria for entering G-codes for positive and negative depression screening results in the electronic health record (EHR)	No improvement reported	Abandoned
Provider education on clinical policy and procedure for integrated care delivery after and BH follow-up care following a positive depression screen	Significant *clinical* and *programmatic* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

HCI: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI developed and carried out a methodologically sound improvement project.
- HCI accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure.

- HCI's intervention testing results demonstrated programmatically significant improvement in the *Depression Screening* measure, and clinically and programmatically significant improvement in the *Follow-Up After a Positive Depression Screen* measure linked to the tested interventions. 

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

Based on PIP validation activities conducted in FY 2022–2023, HCI's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of HCI's PIP, HSAG recommended:

- 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.

Assessment of HCI's Approach to Addressing FY 2021–2022 PIP Recommendations

HCI successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-57 shows the performance measure results for HCI for MY 2020 through MY 2022.

Table 4-57—Performance Measure Results for HCI

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	31.19%	48.51%	53.16%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	71.20%	70.43%	46.26%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	37.58%	36.49%	28.84%	48.22%
Follow-Up After a Positive Depression Screen	34.64%	50.19%	40.86%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	23.70%	33.11%	14.88%	30.56%

HCI: Strengths

The following performance measure rate for MY 2022 increased from the previous year for HCI:

- *Engagement in Outpatient SUD Treatment*

Additionally, the following performance measure rate for MY 2022 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*

HCI: 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*
- *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:

- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of HCI's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, HCI reported implementing the following:

- Created a focus group that focused on two measures: *Follow-Up Within 7 Days of an ED Visit for SUD* and *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*. This group reviewed data to identify individual providers with the greatest ability to effect improvement in each measure. Additionally, COA formed working groups for *Follow-Up Within 7 Days of an ED Visit for SUD* focused on Parkview Medical Center and that included providers, clinical staff, and administrative staff from the ED, BH, and Quality. Representatives also were included from Health Solutions, which is the local CMHC, as well as leading Care Coordination Entity for members of this population. The group met monthly to proceed through process mapping, FMEA, and intervention development to monitor potential impact on performance improvement.
- Created a focus group for the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* measure that focused on Peak View Medical Center, and also included personnel from Health Solutions, which is the local CMHC, as well as leading Care Coordination Entity for members in this population. The group met monthly to proceed through process mapping, FMEA, and intervention development to monitor potential impact on performance improvement.
- Developed a pilot project to address performance on the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure in cooperation with Pueblo DHS. Data use agreements are pending legal review as of the end of SFY 2022–2023 before the trial can begin.

HCI still has the opportunity to address HSAG's recommendation of creating a dashboard to monitor rates monthly or quarterly. Monitoring of rates throughout the year can help create greater visibility and timelier interventions. The ability to stratify the rates across multiple variables such as county, ZIP Code, rendering provider, etc. can help identify more targeted opportunities for improvement. HCI should continue to address the recommendations made by HSAG in an effort to continue to improve upon its rates.

Assessment of Compliance With Medicaid Managed Care Regulations

HCI Overall Evaluation

Table 4-58 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-58—Summary of HCI Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	14	14	12	2	0	0	86%
VI. Grievance and Appeal Systems	35	35	32	3	0	0	91%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**79**	**7**	**0**	**0**	**92%***

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

Table 4-59 presents the compliance scores for record reviews conducted for HCI during FY 2022–2023.

Table 4-59—Summary of HCI Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	74	68	6	26	92%
Grievances	60	50	50	0	10	100%
Appeals	60	60	58	2	0	97%
Totals	**220**	**184**	**176**	**8**	**36**	**96%***

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

HCI: Trended Performance for Compliance With Regulations

Table 4-60 presents, for all standards, the overall percentage of compliance score for HCI for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-60—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; 2022–2023)	**97%**	**94%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**94%**	**86%**
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; 2022–2023)	**83%**	**91%**
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 and Applicable Review Years*	HCI Average—Previous Review	HCI Average—Most Recent Review**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	88%	86%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, HCI demonstrated moderate to high scores, with one score improving and two scores declining from the previous review cycle, indicating a moderately strong understanding of most federal and State regulations.

HCI: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for HCI:

- UM staff members described innovations which included adding automation solutions to the Provider Connect system to improve providers' experiences requesting services; reducing barriers for prior-authorization requests, where appropriate; and working to educate providers about frequently requested services such as methadone, MAT, and other SUD services, which have continued to increase since the implementation of the SUD benefit.
- UM team members participated in annual IRR assessments and met the 80 percent passing rate during the review period.
- HCI made efforts to contract with each specialty type required by the contract and expand its provider network quarter over quarter.
- HCI monitored one quarter of the provider network each quarter to assess adherence to timely appointment standards.
- HCI ensured access to physical and mental health accommodations for members by collecting provider data during the contracting process and posting the specialty accommodations in its online provider directory.
- Community outreach managers were trained to educate the members of their rights to appeal and to request a State fair hearing as well as communicate to the member the limited time frame to receive additional evidence to support the member's appeal request.
- HCI met 97 percent compliance for all 10 appeal sample records.

- HCI met 100 percent compliance for all 10 grievance sample records.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to HCI's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Peer-to-peer reviews to obtain additional information for authorization decisions were stated in policy as a strict 24-hour turnaround, even when HCI had up to 72 hours or 10 business days to make a determination.
- HCI did not have an adequate mechanism to track the time frame of implementing single case agreements (SCAs).
- HCI's Medical Necessity Determination Timelines policy often referred to timelines for URAC standards, which sometimes conflicted with Colorado regulations.
- Only two counties showed access to 3.7 WM, and staff members stated there were no licensed facilities to provide 3.3 LOC.
- HCI's PCP Practitioner Agreement included two incorrect time frames.
- During the interview, staff members were unable to describe current efforts to identify members within Region 4 or assess members whose cultural norms and practices may affect their access to healthcare. Any related initiatives referenced seemed to be new, implemented after the review period (CY 2022), or had not yet started but were in discussion.
- One grievance case should have been investigated as a QOC concern and was not.
- Some documentation incorrectly stated that a verbal appeal request should be followed by a written request, or the coordinator should reach out to the member to obtain a signed appeal.

To address these opportunities for improvement, HSAG recommends HCI:

- Consider the full 72-hour, 10-calendar-day, or 24-calendar-day turnaround (in cases involving extensions) when it is in the member's best interest to wait more than 24 hours for additional information.
- Track the time frame of implementing SCAs, from service request to member appointment, to ensure that when HCI is unable to provide a service within the network, the member receives the service in accordance with timeliness standards.

- Update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the notification time frame is based on the date of the service request until the deadline.
- Correct the timely appointment standards in the PCP Practitioner Agreement.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners and psychiatric units in acute care hospitals.
- Develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare.
- Communicate and clarify with the Department the responsibilities and procedures related to investigating QOC concern issues and revisit HIPAA laws that may or may not apply regarding when Beacon or HCI may share information with providers about a member's care and treatment.
- Update documentation to remove incorrect language stating that the member must follow a verbal appeal request with a written request.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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 recommended 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.

Assessment of HCI's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, HCI updated 14 critical member materials, developed and implemented a monitoring mechanism to ensure that printed materials are sent to the member upon request within five business days, and updated EPSDT documents to include correct *Bright Futures Guidelines* time frames for annual well visits and to enhance annual non-utilizer outreach to ensure it is timely and has a reasonable chance of reaching the member. HSAG recognizes that the informational and EPSDT document updates are likely to result in long-term improvements, and the enhanced

procedures to ensure timely and reasonable member outreach are likely to result in long-term improvement.

Validation of Network Adequacy

HCI: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI met all minimum network requirements for Adult, Family, and Pediatric Primary Care Practitioners (MD, DO, NP, CNS), General and Pediatric Behavioral Health Practitioners, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties, across county designations.
- While HCI did not meet the minimum network requirements for General and Pediatric SUD Treatment Practitioners in all counties across urbanicity, HCI did meet the minimum network requirements for this category in 94.7 percent of contracted counties.
- HCI had match rates above 90 percent for seven out of 10 PDV indicators.

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 network requirements for numerous SUD Treatment Facilities ASAM LOCs across all contracted urban, rural, and frontier counties. While several counties reported high percentages of access, access tended to be between 0 percent to 50 percent for many ASAM LOCs across county and urbanicity.
- HCI did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted urban, rural, and frontier counties.
- Overall, only 52.6 percent of HCI's sampled providers were found in the online provider directory and at the sampled location.
- At 75.0 percent, HCI had the lowest match rate for the street address indicator.
- HCI had a match rate of 74.1 percent for the telephone number indicator.

To address these opportunities for improvement, HSAG recommends HCI:

- Continue to conduct an in-depth review of provider categories for which HCI did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the

contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, HCI should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the HCI data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that HCI seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of HCI's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, HCI reported taking the following actions:

- In the FY 2023 Q2 Network Adequacy Report, the RAEs were no longer required to report the time and distance standards for the Gynecology OB/GYN (MD, DO, NP, CNS) and Gynecology OB/GYN (PA) provider types.
- HCI worked to enhance the network within the region, with a focus on using ARPA funds available to HCI for High Intensity Outpatient Treatment Capacity Expansion to encourage providers to create or expand services within the region, particularly in rural and frontier counties.

Based on the above response, HCI worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-61 presents HCI's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-61—FY 2022–2023 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	92.0%	99.3%
Diagnosis Code	92.0%	92.7%	97.8%
Place of Service	NA	90.5%	99.3%
Service Category Modifier	NA	95.6%	99.3%
Units	NA	95.6%	99.3%
Revenue Code	99.3%	NA	NA
Discharge Status	97.8%	NA	NA
Service Start Date	99.3%	95.6%	99.3%
Service End Date	98.5%	95.6%	99.3%
Population	NA	95.6%	99.3%
Duration	NA	93.4%	99.3%
Staff Requirement	NA	95.6%	99.3%

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

Table 4-62 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 4-62—FY 2022–2023 BH EDV Over-Read Agreement Results by BH Service Category for HCI

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Diagnosis Code	90.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	10.0%	0.0%
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%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
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.

HCI: Strengths

Based on RAE 411 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI self-reported high overall accuracy, with 90 percent accuracy or above for all five inpatient services data elements, all 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that HCI's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with four of the five inpatient services data elements, nine of the 10 psychotherapy services data elements, and nine of the 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in HCI's EDV results, for the *Service Category Modifier* data element, there was a 10 percent agreement rate between HCI's reviewers and HSAG's reviewers for psychotherapy services and a 0 percent agreement rate for residential services.

To address these opportunities for improvement, HSAG recommends HCI:

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

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended HCI consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of HCI's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

HCI reported completing a RAE 411 EDV training with its provider network prior to the start of the RAE 411 audit. The training included an overview of the audit and documentation tips for providers to be successful in the audit. HCI asked that each provider use the training as part of its own internal training to enhance documentation related to the audit. HCI offered training to providers who fell below 90 percent, or placed the provider on a corrective action. Additionally, HCI worked with a provider on a QUIP project, which focused on low-performing encounter service categories. The facility was provided training and subsequent chart audits took place over three months to test the validity of the targeted intervention.

Based on HCI's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

HCI: Adult CAHPS

Table 4-63 shows the adult CAHPS results for HCI for FY 2021–2022 and FY 2022–2023.

Table 4-63—Adult CAHPS Top-Box Scores for HCI

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	57.0%	54.5% ↓
Rating of All Health Care	52.4%	47.9%
Rating of Personal Doctor	66.7%	62.7%
Rating of Specialist Seen Most Often	65.6%+	62.4%+
Getting Needed Care	86.1%+	81.3%
Getting Care Quickly	86.9%+	81.2%+
How Well Doctors Communicate	92.8%	94.1%
Customer Service	90.0%+	95.2%+ ↑

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

HCI: Strengths

The following measure's FY 2022–2023 score for HCI was statistically significantly higher than the 2022 NCQA national average:

- *Customer Service*

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

The following measure's FY 2022–2023 score for HCI was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Health Plan*

To address these low CAHPS scores, HSAG recommends HCI:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

HCI: Child CAHPS

Table 4-64 shows the child CAHPS results for HCI for FY 2021–2022 and FY 2022–2023.

Table 4-64—Child CAHPS Top-Box Scores for HCI

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	67.9%	69.6%
Rating of All Health Care	56.8%	68.9% ▲
Rating of Personal Doctor	74.0%	67.2% ↓

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Specialist Seen Most Often	78.6%+	82.6%+
Getting Needed Care	81.6%+	84.9%+
Getting Care Quickly	84.5%+	88.4%+
How Well Doctors Communicate	95.9%	96.4%
Customer Service	82.0%+	93.1%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

HCI: Strengths

The following measures' FY 2022–2023 scores for HCI were higher, although not statistically significantly, than the 2022 NCQA national averages:

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

The following measure's FY 2022–2023 score for HCI was statistically significantly higher than the FY 2021–2022 score:

- *Rating of All Health Care*

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

The following measure's FY 2022–2023 score for HCI was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends HCI:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with parents/caretakers of child members.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, HCI reported engaging in the following QI initiatives:

- Created a CAHPS survey tip sheet in both English and Spanish, which explains what a CAHPS survey is and the importance of taking the CAHPS survey. HCI presented this tip sheet to participants of the QIC, the Member Services Subcommittee, and the Care Coordination meeting in January 2023. Additionally, this tip sheet was placed in the January 2023 edition of the provider newsletter and placed on HCI's website (see CAHPS Survey Information). The goal of creating and distributing this tip sheet is to encourage healthcare providers and member advocates to educate and promote the importance of completing the survey to their members.
- CAHPS results were discussed during the November 2022 Member Experience Advisory Committee. In addition to an overview of the survey and specific results for HCI, specific content was provided on after-hours care options throughout the region. Discussion was facilitated on the best options to disseminate this information to reach HCI members.

Assessment of HCI's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that HCI addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with HCI.

Quality Improvement Plan

Table 4-65 presents HCI's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-65—Summary of HCI QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Place of Service	85%	100%	100%	100%

**Green shading indicates accuracy of 90 percent and higher.*

HCI: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI reached 100 percent accuracy in the QUIP for the *Place of Service* data element in the psychotherapy services claim type, which, notably, improved from 85 percent to 100 percent in month one and maintained 100 percent accuracy for months two and three.
- Key interventions throughout the QUIP included continued training for providers that included audits to determine if the error rate was reduced. Training also focused on addressing the 411 audits as well as specific errors. Result showed significant improvements that demonstrated effectiveness and sustainability.

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

HSAG found the following opportunities for improvement:

- HCI reported that the baseline low accuracy results were due to its staff members' lack of awareness of the intricacies of the USCS Manual and application with its EHR system. Failure modes included staff members not documenting according to the USCS Manual requirements and understanding how it applies within the pilot partner's EHR.

To address these opportunities for improvement, HSAG recommends HCI:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

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.

Assessment of HCI's Approach to Addressing FY 2021–2022 QUIP Recommendations

HCI was not required to participate in the FY 2021–2022 QUIP activities; therefore, this section is not applicable to HCI.

Mental Health Parity Audit

Table 4-66 displays the MHP Audit compliance scores for HCI for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-66—FY 2022–2023 MHP Audit Score for HCI

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
HCI	4	94%	Inpatient	93%	92%v
			Outpatient	89%	

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

HCI: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI delegated UM activities to Beacon and followed policies and procedures regarding adequate monitoring and oversight of delegated activities.
- Beacon used nationally recognized UR criteria, including InterQual, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- HCI required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Additionally, Beacon reported the last IRR testing occurred in summer of 2022, and all UM staff members exceeded the minimum score of 80 percent.
- In all cases reviewed, Beacon followed its policies and procedures related to which services require prior authorization. In most cases, Beacon notified providers of the denial determinations by telephone or email, and providers received a copy of the NABD within the required time frame.

- The denial determinations were made by a qualified clinician, and requesting providers were offered a peer-to-peer review.
- Most NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system. Additionally, all NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from HCI when filing, and access to pertinent records. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity.
- During the MHP interview, Beacon staff members reported that when a particular LOC is denied and a lower LOC is recommended, if the member has been receiving services and the denial is related to a concurrent request to continue services, care coordination staff are part of the member's discharge planning process and would coordinate follow-up. If the member had not been receiving services and the denial was related to a new request, the NABD may refer the member to care coordination to find a provider or to contact HCI/Beacon to request care coordination services.

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

HSAG found the following opportunities for improvement:

- Beacon had submitted a full sample list of outpatient records to HSAG for review; however, most of the outpatient records submitted were administrative denials which were not within the scope of the reviews this year, as determined by the Department. During the MHP interview, Beacon staff members clarified that the administrative denials were documented incorrectly in the system as medical necessity denials, causing the sample to be pulled incorrectly.
- Multiple records did not include notification to the provider and/or member regarding the denial determination within the required time frame.
- While the NABDs included the required content, some NABDs scored high reading grade levels using the Flesch-Kincaid readability test.
- Inpatient and residential SUD NABDs included the required ASAM language; however, applicable UM documents and policies and procedures did not outline the requirement for the NABDs to include ASAM language.

To address these opportunities for improvement, HSAG recommends HCI:

- Periodically train and conduct record audits to ensure that UM staff members are correctly identifying and documenting denial reasons within the UM system.

- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.
- Provide continuous and regular training for UM staff to ensure that NABDs are written at an easy-to-understand reading grade level. Additionally, should Beacon use any medical terminology, HSAG recommends including a plain language explanation next to any medical terminology.
- As a best practice, update applicable UM documents and policies and procedures to outline the required ASAM language within inpatient and residential SUD NABDs.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of HCI's Approach to Addressing FY 2021–2022 MHP Recommendations

HCI reported addressing HSAG's recommendations by:

- Providing additional training to UM staff members in June 2022 regarding documentation requirements for denial determinations, which include the UR criteria used and additional information needed within the NABD to help members better understand the denial determination.
- Conducting ongoing monitoring through quality peer and/or supervisor audits to assess compliance. If any deficiencies were observed, the affected staff member(s) received additional training to improve their understanding of the requirements.
- Clarifying Beacon's responsibility for coordinating the recommended alterative service(s) after a particular LOC is denied through the UM training. UM staff members were instructed to inform a member's care coordination team whenever an alternative service is recommended to reduce potential gaps in care, and care coordination referrals must be documented in the member's record.

Overall, HSAG anticipates HCI's responses to the recommendations are likely to improve overall processes. HCI and Beacon still have the opportunity to continue addressing HSAG's recommendations

and improving documentation within the NABDs while still ensuring the NABDs are written at an easy-to-understand reading grade level. HCI and Beacon should continue to address the recommendations made by HSAG and continue to make updates, conduct staff trainings, and monitor NABD language and content.

QOC Concern Audit

The QOC Concern Audit was not conducted with HCI in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended HCI:

- Implement ongoing staff training on the Colorado-specific QOC grievance process.
- Review and update applicable policies and process documents to:
  - Include a 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, HSAG recommended HCI 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.

Assessment of HCI's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

HCI reported addressing HSAG's recommendations by:

- Conducting investigations of potential QOC concerns/grievances through the QM department and evaluating findings for appropriate follow-up, corrective action, and monitoring through the QOC Committee that meets once per month, at minimum.
- Offering the Adverse Incident reporting form digitally to providers at each quarterly training and informing providers of the reporting process at least twice per year through mass distribution email. Providers, HCI staff members, and/or other concerned parties can report QOC concern/grievance issues by submitting the Adverse Incident reporting form to the Quality department.

- Updating policies and procedures and workflows to comply with contractual requirements.
- Providing acknowledgement and resolution letters to any party reporting a QOC concern/grievance issue.
- Sending the Department quarterly reports of founded QOC grievance cases and collaborating with the Department to determine the contractual requirements of investigating QOC concerns and QOC grievances for out-of-network and noncontracted provider complaints.
- Increasing tandem work with the grievance coordinator/OMFA to include, but not limited to, collaborating on the updated Department contractual changes for QOC grievance investigation requirements.
- Adding race, ethnicity, and disability status to HCI's internal QOC grievance tracking process and integrating with demographic data when available.

HSAG anticipates HCI's response to the recommendations is likely to improve overall processes and compliance with contractual requirements. HCI should continue addressing the recommendations made by HSAG and prepare for guidance from the Department for upcoming contractual changes and requirements.

EPSDT Audit

Table 4-67 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-67—FY 2022–2023 EPSDT Audit Findings for HCI

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	75%	33%	63%
Post-Denial Record Review	83%	42%	63%

HCI: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HCI hosted Provider Roundtables (two during the review period) and RAE 101 EPSDT Early Childhood Mental Health training in September 2022. The HCI website included information regarding EPSDT tip sheets, Bright Futures, provider alerts for training opportunities, and details regarding HCI's QUIP and multi-system involved populations from the review period.
- HCI submitted seven trainings for internal staff members during the review period including: care coordination, provider relations, call center, member engagement, and trainings provided in collaboration with external partners at roundtable events.
- Policies, procedures, and quarterly reports indicated IVR and texting scripts were used. Quarterly reports stated that HCI initiated between one and 2.5 average attempts per member in FY 2021–2022 Q4. Furthermore, most members in the non-utilizer sample received attempts to outreach.
- HCI had a process for ongoing outreach to members who opted to receive texts. HCI had multiple campaign types, such as well care, developmental messages, dental care, flu shot, COVID-19 messaging, stress relief, and a satisfaction survey campaign.
- Outreach reports indicated that by the end of the review period, Carelon had implemented birthday mailers at a reported 100 percent outreach success rate.
- HCI was one of the few MCEs in which most NABDs included member-specific next steps and recommended alternate LOCs, and seven of the 15 files indicated assistance with scheduling appointments, even if the language was somewhat generic.
- Within most applicable files related to a noncovered diagnosis denial, HCI called the requesting provider to advise that the services may be covered under FFS.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- Multiple cases indicated the member only received one IVR outreach attempt; however, all of these cases were considered successful since HCI left a voicemail.
- HCI's policies and procedures did not detail how HCI works with the Department to request EPSDT services or submit additional documentation as evidence of how HCI advises members of benefits available under the State plan but not covered by the RAE. Additionally, in five applicable cases,

there was no documentation of HCI working with the State or sending any information to inform the State of the denial.

To address these opportunities for improvement, HSAG recommends HCI:

- Discuss with the Department whether voicemails may be considered completed outreach.
- Develop a desktop procedure that outlines how HCI works with the Department to obtain EPSDT services for members, when necessary.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- Record review of denial determinations showed HCI's documentation of medical necessity criteria to be limited. Similarly, the Medical Necessity Determination and Medical Necessity Determination Timelines policies contained language that could be limiting to the scope of the review.
- Denial records reviewed included only brief documentation of phone conversations with providers and UM notes were limited overall. Carelon staff members noted updates to expand UM documentation procedures that occurred during the summer of 2022; however, this was only mentioned in terms of SUD denial review documentation and not applied for other types of UM reviews.
- HCI did not submit adequate documentation of a thorough medical necessity review performed by clinical staff members.
- Documentation provided by HCI indicated "no risk assessment" in the case files for the non-utilizer sample population, and HSAG could not find evidence of implementation to demonstrate HCI followed up with members to offer services or support for SHCN.
- HCI did not use mailings when electronic attempts at outreach failed.
- Within the 15 sample denial cases, HSAG determined that Carelon did not consider all of the following three components for any member: the service to assist in maintaining the member's level of functioning, long-term needs, and other needs.
- Denial cases involving developmental disability, neurological or neurocognitive disorder, or traumatic brain injury did not show evidence that HCI followed its stated procedure to outreach the requesting provider to confirm or clarify symptomology and diagnoses driving the behaviors.
- Five administrative denials reviewed did not indicate a referral to care coordination for follow-up or working with the requesting provider.
- HCI did not always send an NABD to members regarding their denials.

- Staff members described delegated care coordination tasks in which the CMHCs would assist with referrals and discharge planning; however, documentation was not submitted as evidence of these efforts in any of the denial records reviewed.

Although these findings did not lead to recommendations, HSAG informed HCI of these findings within the report. HCI should work on addressing these findings to improve processes, procedures, trainings, and communication with the Department.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-68 presents the number of cases in the sample that HSAG reviewed for HCI and the percentage of cases in which HSAG reviewers agreed with HCI's denial determination. Due to SOPs within Beacon's UR systems, eight of the denials in the review sample were triggered at the end of an authorization period in which the provider had not requested continued services. Those cases were excluded from the sample.

Table 4-68—HCI Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
HCI	127	119[1]	100%
[1] Due to eight samples being not applicable, the total applicable sample is 119.			

HCI: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for HCI:

- HSAG reviewers agreed with all HCI denial decisions.
- Despite HCI's overall struggles with distributing notices, the contents of the notices had the highest scores across the MCEs, surpassing the next highest MCE's total content score by 2 percentage points (86 percent compared to 84 percent). HCI's score was 6 percentage points above the overall MCE average (80 percent).

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Many of the Beacon files lacked clinical documentation of the authorization request and included only minimal notes from telephone calls. Staff members indicated that this was standard practice for the majority of FY 2021–2022.
- In 127 cases reviewed, documentation showed that 41 of the 119 applicable cases documented notices to members. Out of the 41 NABD letters, 35 were mailed within timeliness requirements.

To address these opportunities for improvement, HSAG recommends HCI:

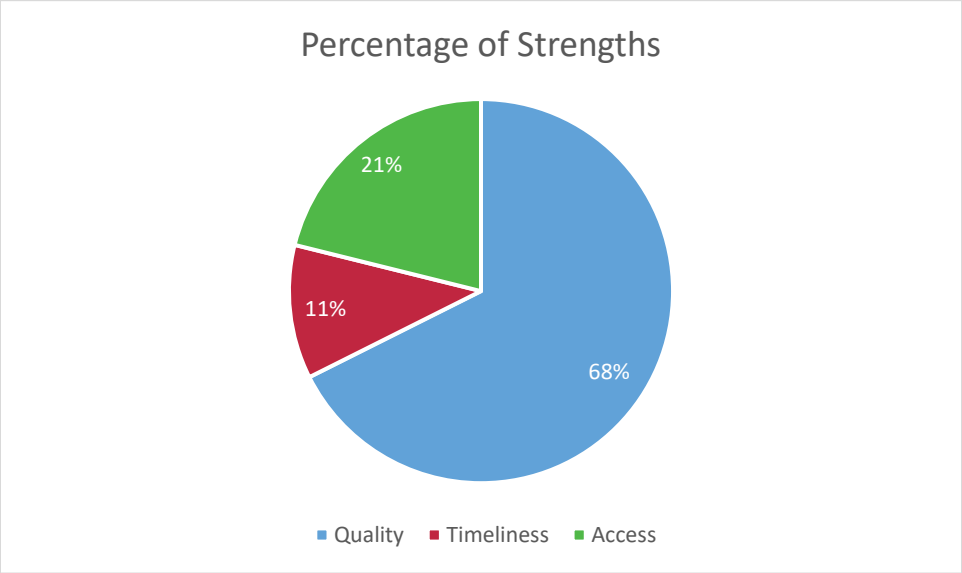
- Update its policies, procedures, and processes to ensure that sufficient clinical documentation is received and included in each service authorization file to support the authorization approval or denial.
- Update policies, procedures, and processes to ensure that members receive a NABD when required.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

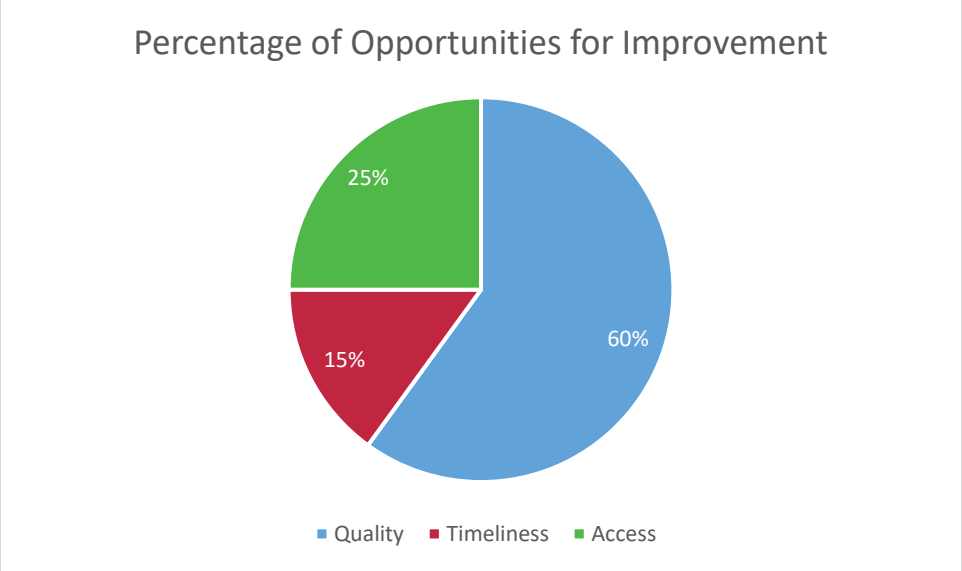
Region 5—Colorado Access

Figure 4-9—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 4-10—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, timeliness, and accessibility of care and services.

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, 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 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, COA Region 5 established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-69 and Table 4-70 summarize COA Region 5's PIP activities that were completed and validated in FY 2020–2021. Table 4-69 provides the SMART Aim statements that COA Region 5 defined for the two PIP outcome measures in Module 1.

Table 4-69—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 4-70 summarizes the preliminary key drivers and potential interventions COA Region 5 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-70—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.

Table 4-71 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-71—Intervention Testing Plan 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	• 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	• Percentage of depression screening claims (CPT code G8510 or G8431) from Inner City Health Center with a corresponding

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
depression screening performance		education, and training	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 • Provider is unaware of unmet BH needs	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Members are educated about treatment options and engaged • Member access, knowledge, and engagement	• 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 depression screening or BH follow-up and who received a treatment hesitancy educational flyer

FY 2022–2023 PIP Activities

In FY 2022–2023, COA Region 5 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed COA Region 5's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated COA Region 5's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for COA Region 5's PIP are presented in Table 4-72. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-72—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens in well visits among members ages 12 years and older who receive care at Every Child Pediatrics and Inner-City Health Center.	56.39%	61.99%	88.83%	*Yes*
Follow-Up After a Positive Depression Screen				
The percentage of *Follow-Up After a Positive Depression Screen* visits completed among members ages 12 years and older within 30 days of a positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Inner-City Health Center.	44.18%	70.59%	54.29%	*No*

To guide the project, COA Region 5 established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during a well visit at Every Child Pediatrics or Inner-City Health Center from 56.39 percent to 61.99 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 44.18 percent to 70.59 percent, through the SMART Aim end date of June 30, 2022. COA Region 5's reported SMART Aim measure results demonstrated that the Depression Screening goal was exceeded, with the highest rate achieved, 88.83 percent, representing a statistically significant increase of

32.44 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 54.29 percent, representing an improvement of 10.11 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, COA Region 5 completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-73 summarizes COA Region 5's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-73—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Inner-City Health Center workflow and coding changes: capture all depression screening services for members more accurately and better monitor depression screening performance.	Significant *programmatic* improvement for *Depression Screening*	Adopted
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of electronic health record (EHR) to support protocol and coding standardization, using automation where possible.	*Evaluation results were inconclusive*	Adopted
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.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
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.	*Programmatic* and *clinical* improvement for *Depression Screening*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

COA Region 5: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- COA Region 5 developed and carried out a methodologically sound improvement project.
- COA Region 5 accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure, and non-statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure.
- COA Region 5's intervention testing results demonstrated programmatically significant improvement in *Depression Screening* and *Follow-Up After a Positive Depression Screen*, and clinically significant improvement in *Follow-Up After a Positive Depression Screen*, linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, COA Region 5's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of COA Region 5's PIP, HSAG recommended:

- 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.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 PIP Recommendations

COA Region 5 successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-74 shows the performance measure results for COA Region 5 for MY 2020 through MY 2022.

Table 4-74—Performance Measure Results for COA Region 5

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	35.29%	36.65%	49.35%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	73.69%	56.03%	49.38%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	37.42%	35.25%	30.19%	48.22%
Follow-Up After a Positive Depression Screen	45.87%	39.21%	49.02%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	20.79%	28.57%	28.93%	30.56%

COA Region 5: Strengths

The following performance measure rates for MY 2022 increased from the previous year for COA Region 5:

- *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 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:

- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, COA Region 5 reported implementing the following:

- Performance metric dashboards used for real-time data trend monitoring, tracking, and evaluating of programming and interventions tied to performance metrics, for the internal and external reporting with stakeholders, and for communicating data during routine meetings and collaboration with the Department.
- A Metric Steward Program in July 2022.
- Collaboration with providers on best practices and specific interventions aimed at improving performance metrics such as the *Follow-Up After a Positive Depression Screen* metric.
- A series of workgroups with a select cohort of providers to dive into these performance metrics. This was designed for providers to collaborate and share best practices to drive performance and inform opportunities to scale interventions across the network.

HSAG recognizes that the implementation of the dashboard and the provider workgroup are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 5 Overall Evaluation

Table 4-75 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-75—Summary of COA Region 5 Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	28	4	0	0	88%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	35	35	34	1	0	0	97%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**81**	**5**	**0**	**0**	**94%***

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

Table 4-76 presents the compliance scores for record reviews conducted for COA Region 5 during FY 2022–2023.

Table 4-76—Summary of COA Region 5 Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	71	64	7	29	90%
Grievances	60	56	56	0	4	100%
Appeals	60	53	53	0	7	100%
Totals	**220**	**180**	**173**	**7**	**40**	**96%***

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

COA Region 5: Trended Performance for Compliance With Regulations

Table 4-77 presents, for all standards, the overall percentage of compliance score for COA Region 5 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-77—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; 2022–2023)	**80%**	**88%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**100%**	**100%**
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)	94%	94%
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	**83%**	**97%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, each standard 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 2022–2023, HSAG found the following strengths for COA Region 5:

- Policies, procedures, and reporting documents outlined a comprehensive UM approach to review and authorize covered services using medical necessity and InterQual criteria in compliance with regulatory guidelines. UM staff members participated in annual IRR testing to ensure criteria are applied consistently.
- The provider manual and website included accurate information regarding time and distance standards, and provider network and quality department staff members also outreached providers to inform them of timely appointment standards prior to conducting monitoring activities such as secret shopper. CAPs for providers who failed to comply with timely appointment standards were individualized based on the type of noncompliance documented and have shifted to an "opportunity" lens.
- Cultural competency efforts have been a focus in the organization and staff members reported the addition of a vice president of DEI and an expanded team of DEI "consultants." Targeted outreach and engagement programs described during the interview included the following member groups: Latinx, homeless, refugee, and members recently released from prison. These member populations were noted as top priorities during the CY 2022 review period related to cultural competency efforts.
- Staff members described how they inform members of their rights if a member contacts COA Region 5 to file a grievance and the ways the member or the member's authorized representative can submit a grievance. The member can submit a grievance by phone, email, online, or fax to customer service, care managers, or other staff members, and all staff are trained to submit grievances to the grievance team.
- When a member filed an appeal, in addition to sending a written acknowledgement letter, the COA Region 5 appeals coordinator verbally contacted the member to ensure that the member, or the member's representative, was aware that he or she has the right to submit documents, records, and other information, and that all comments will be considered by the decision maker without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to COA Region 5's system with no restriction.

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

HSAG found the following opportunities for improvement:

- HSAG recommends that COA Region 5 include the core components of medical necessity as described in the federal definition (42 CFR §438.210[a][5]) as part of COA Region 5's policy definition.
- NABDs included clinical terminology that may not be easy for the member to understand.
- COA Region 5 did not mail an NABD to the member in one case.
- COA Region 5 did not make the denial decision or send the NABD within the 72-hour expedited time frame in one case.
- Geoaccess compliance reports, quarterly *Network Reports*, and the *Network Adequacy Plan* each included details of a few gaps in COA Region 5's provider network.
- One out of the 10 sample grievance records did not comply with the grievance acknowledgement letter time frame set forth by the State.
- An old policy inaccurately stated that the member must follow an oral request of an appeal in writing.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Update its procedures to further delineate provider claims issues, which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service in a timely manner.
- Enhance its monitoring procedures to ensure that members are notified in a timely manner.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners, specifically ASAM LOCs 3.3, 3.7, and 3.7 WM.
- Enhance its monitoring system to ensure that grievance acknowledgement letters are sent in a timely manner.
- Remove any incorrect statement that requires the member to follow an oral request in writing to adhere to federal regulations.
- Enhance its monitoring procedures to ensure that members are notified in a timely manner.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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 updated federal language "or 30 days prior to the effective date of the termination" when notifying the member of a provider termination.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, COA Region 5 updated policies and procedures to include clarification that a member may submit a complaint and it will be resolved within the state-required time frame and the policy language, language regarding the time frame to send the member a provider termination notice, and language in the *New Member Booklet* to inform members of their right to receive documents upon request within five business days. HSAG recognizes that policy and member informational document updates are likely to result in long-term improvements.

Validation of Network Adequacy

COA Region 5: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- COA Region 5 demonstrated strength in both PH and BH networks, meeting minimum network requirements for Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA), Family Practitioners (MD, DO, NP, CNS, PA), General and Pediatric Behavioral Health Practitioners, General and Pediatric Psychiatrists and other Psychiatric Prescribers, General and Pediatric SUD Treatment Practitioners, and Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in the contracted county. 
- COA Region 5 met all minimum network requirements for SUD Treatment Facilities ASAM LOCs 3.1, 3.2 WM, 3.5, 3.7, and 3.7 WM in the contracted county. 
- COA Region 5 had match rates above 90 percent for eight out of 10 PDV indicators. 

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 network requirements for SUD Treatment Facilities—ASAM LOC 3.3 in the contracted urban county. 
- Overall, 40.9 percent of COA Region 5's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 46.7 percent were found at the sampled location. While COA Region 5 noted that providers participating with a CMHC or other treatment center are not listed individually in the online provider directory, these providers are listed individually in COA Region 5's provider data, resulting in a high rate of mismatched data for this indicator. 
- COA Region 5 had a match rate of 8.9 percent for the accepting new patients indicator. However, new patient acceptance information is missing from the COA online provider directory. 
- COA Region 5 had a match rate of 59.9 percent for the telephone number indicator. 

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Continue to conduct an in-depth review of provider categories for which COA Region 5 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, COA Region 5 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure COA Region 5's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that COA Region 5 seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, COA Region 5 reported taking the following actions:

- COA Region 5 continued to seek opportunities to expand the care network, including Gynecology (Mid-Level practitioners) and the Pediatric Primary Care (Mid-Level practitioners) network categories, to ensure adequate network providers and access to care. Building on the foundation of the existing network, COA Region 5 continued to use various resources to further target potential additions and grow the network of providers.
- COA Region 5 remained dedicated to contracting with every willing state-validated provider to become part of the COA Region 5 network, regardless of their location, provided they meet the credentialing and contracting criteria.

Based on the above response, COA Region 5 worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-78 presents COA Region 5's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-78—FY 2022–2023 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	87.6%	97.1%
Diagnosis Code	93.4%	95.6%	99.3%
Place of Service	NA	77.4%	99.3%
Service Category Modifier	NA	87.6%	97.1%
Units	NA	98.5%	99.3%
Revenue Code	96.4%	NA	NA
Discharge Status	89.8%	NA	NA
Service Start Date	97.8%	98.5%	99.3%
Service End Date	97.8%	98.5%	98.5%
Population	NA	98.5%	99.3%
Duration	NA	92.7%	99.3%
Staff Requirement	NA	98.5%	99.3%

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

Table 4-79 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 4-79—FY 2022–2023 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%
Diagnosis Code	90.0%	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%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
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.

COA Region 5: Strengths

Based on RAE 411 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- COA Region 5 self-reported high overall accuracy, with 90 percent accuracy or above for four of the five inpatient services data elements, seven of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- 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 reported 100 percent agreement with four of the five inpatient services data elements, all 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 the over-read results suggest confidence in COA Region 5's EDV results, COA Region 5's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with a 77.4 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

COA Region 5 reported implementing CAPs for providers that score below a 95 percent and have a sufficient number of records to assess general documentation practices. The CAPs may include requirements such as root cause analyses, retraining staff, systems enhancements, and/or provider re-audits. COA Region 5 reported offering providers education and training on quality documentation in collaboration with its Quality Department, Practice Support Team, and provider network managers.

Based on COA Region 5's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

COA Region 5: Adult CAHPS

Table 4-80 shows the adult CAHPS results for COA Region 5 for FY 2021–2022 and FY 2022–2023.

Table 4-80—Adult CAHPS Top-Box Scores for COA Region 5

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	58.0%	56.0%
Rating of All Health Care	52.2%+	50.0%
Rating of Personal Doctor	76.4%	64.6% ▼
Rating of Specialist Seen Most Often	70.0%+	72.3%+
Getting Needed Care	78.3%+	78.9%
Getting Care Quickly	78.0%+	81.8%+
How Well Doctors Communicate	93.5%+	93.7%
Customer Service	85.6%+	87.4%+

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

COA Region 5: Strengths

The following measures' FY 2022–2023 scores for COA Region 5 were higher, although not statistically significantly, than the 2022 NCQA national averages:

- *Rating of Specialist Seen Most Often*

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

The following measures' FY 2022–2023 scores for COA Region 5 were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measure's FY 2022–2023 score for COA Region 5 was statistically significantly lower than the FY 2021–2022 score:

- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends COA Region 5:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with members.

COA Region 5: Child CAHPS

Table 4-81 shows the child CAHPS results for COA Region 5 for FY 2021–2022 and FY 2022–2023.

Table 4-81—Child CAHPS Top-Box Scores for COA Region 5

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	77.3%	75.1%
Rating of All Health Care	74.1%	70.6%
Rating of Personal Doctor	84.9%	83.5% ↑
Rating of Specialist Seen Most Often	77.8%+	85.9%+ ↑
Getting Needed Care	81.0%	81.2%
Getting Care Quickly	84.2%+	80.9%
How Well Doctors Communicate	92.6%	96.4% ▲ ↑
Customer Service	88.8%+	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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

COA Region 5: Strengths

The following measures' FY 2022–2023 scores for COA Region 5 were statistically significantly higher than the 2022 NCQA national averages:

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

The following measure's FY 2022–2023 score for COA Region 5 was statistically significantly higher than the FY 2021–2022 score:

- *How Well Doctors Communicate*

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

The following measures' FY 2022–2023 scores for COA Region 5 were lower, although not statistically significantly, than the 2022 NCQA national averages:

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

The following measures' FY 2022–2023 scores for COA Region 5 were lower, although not statistically significantly, than the FY 2021–2022 scores:

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

To address these low CAHPS scores, HSAG recommends COA Region 5:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for parents/caretakers of child members.
- Direct parents/caretakers to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, COA Region 5 reported engaging in the following QI initiatives:

- Collected and analyzed data from a fourth iteration of a member satisfaction survey administered in June 2022, and administered a fifth member satisfaction survey, which is currently being analyzed, in March 2023, to better understand member experience and perceptions of care. The former survey included questions that focus on scheduling, appointment access, and what COA Region 5 could improve for members. The latter survey included survey questions that explored how members identify racially, culturally, and ethnically; how that identification impacts their healthcare experience; and how COA Region 5 can improve the member experience.
- Developed and implemented a CAHPS communication plan in 2023. Information describing what the CAHPS survey is, the timeline for data collection, and the value it brings to members, providers, and the Health First Colorado system was communicated in the following venues: 1) provider manual, 2) quarterly provider newsletter, 3) internal COA Region 5 employee newsletter, 4) member newsletter, and 5) COA Region 5 social media platforms.
- Continued the COA Region 5 customer service quality monitoring program in 2023, including continuous monitoring of NPS scores, CSR quality audits, ongoing collaboration, and continued internal member satisfaction survey iteration and administration. If trends are identified, additional training is provided to relevant departments.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that COA Region 5 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with COA Region 5.

Quality Improvement Plan

Table 4-82 presents COA Region 5's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-82—Summary of COA Region 5 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Primary Diagnosis Code	85%	100%	50%	100%

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Procedure Code	72%	100%	100%	100%
	Diagnosis Code	85%	100%	100%	100%
	Place of Service	72%	100%	100%	100%
	Service Category Modifier	72%	100%	100%	100%
	Units	89%	100%	100%	100%
	Duration	85%	100%	100%	100%
	Staff Requirement	82%	100%	100%	100%

**Green shading indicates accuracy of 90 percent and higher.*

COA Region 5: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- COA Region 5 reached 100 percent accuracy in the QUIP for all eight data elements. Most notably, three psychotherapy services data elements (*Procedure Code*, *Place of Service*, and *Service Category Modifier*) improved from 72 percent to 100 percent in month one and maintained 100 percent accuracy throughout the intervention period.
- Key interventions for the QUIP included issuing CAPs to the pilot partners, directing additional training and education on the topic.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- COA Region 5 reported that it had low accuracy results because the diagnosis listed on the claim did not match the diagnosis on the service documentation, provider signatures and duration were not included in service documentation, and service documentation did not match the place of service listed on the claim.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that COA Region 5 maintain oversight of encounter data and communication with providers to ensure that accuracy rates remain above the 90 percent threshold, as well as provide targeted training and/or outreach to address specific areas of non-accuracy

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 QUIP Recommendations

COA Region 5 reported that it implemented CAPs for providers that scored below 95 percent accuracy (if the provider had a sufficient number of records to assess). The CAPs consisted of root cause analyses, retraining staff members, systems enhancements, and provider audits. Education was offered to providers regarding quality documentation, and COA Region 5 continues to maintain a claims audit program. HSAG recognizes that training and consistent auditing, paired with feedback, is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-83 displays the MHP Audit compliance scores for COA Region 5 for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-83—FY 2022–2023 MHP Audit Score for COA Region 5

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
COA	5	99%	Inpatient	93%	94%v
			Outpatient	94%	

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

COA Region 5: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- COA Region 5 used nationally recognized UR criteria, including InterQual, for MH determinations and ASAM LOC criteria for SUD determinations.
- COA Region 5 required UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- COA Region 5 followed its prior-authorization list and UM policies and procedures with regard to which services were subject to prior authorization.

- In all cases reviewed, the denial determination was made by a qualified clinician, and all applicable cases contained evidence that the peer-to-peer review was offered to the requesting provider.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in COA Region 5's UM system.
- COA Region 5's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA Region 5 when filing, access to pertinent records, and the reason for the denial.

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 use nationally recognized UR criteria (InterQual or ASAM) within an outpatient record reviewed.
- In some cases, COA Region 5 did not notify the provider of the denial determination or send the NABD to the member within the required time frame.
- The NABDs reviewed did not always score at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Ensure all denial determinations due to medical necessity use established UR criteria (InterQual or ASAM).
- Enhance monitoring procedures to ensure that the provider is made aware of the denial determination within the required time frame and the member is sent the NABD within the required time frame.
- Conduct periodic staff training and monthly record audits to ensure NABDs are sent at an easy-to-understand reading grade level for the member.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 5 found to be present or not present, related to the criteria).

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 MHP Recommendations

COA Region 5 reported addressing HSAG's recommendations by:

- Monitoring denial cases to ensure that NABDs are sent to members in a timely manner.
- Conducting staff training and internal audits to confirm complete documentation of the peer-to-peer review process.

COA Region 5 still has the opportunity to address HSAG's recommendation of including the specific name of the criteria used to make the denial determination within the NABD. COA Region 5's reported updates will most likely demonstrate improvement to overall UM processes. COA Region 5 should continue to address the recommendations made by HSAG in an effort to help the member better understand the circumstances and criteria used to make the denial determination, ensure timeliness regarding sending the NABD within the required time frame, and achieve MHP compliance.

QOC Concern Audit

The QOC Concern Audit was not conducted with COA Region 5 in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended COA Region 5:

- Continue ongoing staff training on the Colorado-specific QOC grievance processes.
- 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, HSAG

recommended COA Region 5 implement a process for QOC concern 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 QOC concerns received, according to contractual requirements. Currently, COA Region 5 is reporting this information to the Department annually.

Assessment of COA Region 5's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

COA Region 5 reported addressing HSAG's recommendations by:

- Developing a QOC training for internal staff members which outlines obligations to report QOCs and the reporting process. COA Region 5 incorporated the training into the care manager learning pathway, which was completed by all COA Region 5 CM staff members in January 2023 and is ongoing for new hires. COA Region 5 reported that it will continue to update the QOC training to reflect contract changes.
- Continuing tandem work between the quality and grievance teams to identify grievances that meet QOC thresholds to ensure timely investigation.
- Reporting QOCs to the Department according to contractually outlined requirements. COA Region 5 stated that it will report QOCs to the Department more regularly based on updates to contractually defined QOC reporting requirements.

HSAG anticipates COA Region 5's response to the recommendations are likely to improve overall processes and compliance with contractual requirements. COA Region 5 should continue to address the recommendations made by HSAG and continue to make updates based on guidance from the Department for upcoming contractual changes and reporting requirements.

EPSDT Audit

Table 4-84 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-84—FY 2022–2023 EPSDT Audit Findings for COA Region 5

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	50%	75%
Post-Denial Record Review	92%	58%	75%

COA Region 5: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- Policies, procedures, documentation, and interviews with staff members confirmed that COA Region 5 takes the full definition of "EPSDT medical necessity" into consideration. UM staff members described reviewing any collateral clinical documentation including the provider request, CM notes, InterQual, and consulting with the medical director before making any denial or partial denial decisions. Additionally, COA Region 5's documentation demonstrated a strong process for UM reviewers to consider medical necessity.
- Staff members described specialty UM reviewers, such as LPC, all of whom had been trained to follow the high needs pediatric workflow and how to coordinate with the Department regarding EPSDT service needs.
- COA Region 5's website included information about: maternal and child health; public health, mental health, and education programs; social services programs; WIC supplemental food program; SNAP; NFP; home visit programs; childcare programs; and cash assistance programs.
- COA Region 5 distributed updated EPSDT policies, procedures, and resources through the monthly provider newsletter, *The Navigator*. COA Region 5 focused on maternal health programming during the FY 2021–2022 review period, specifically the Text4Baby and Healthy Mothers, Healthy Babies campaigns.
- Staff members were trained on EPSDT benefits using Department-approved resources.
- Assessments submitted by COA Region 5 included aspects of EPSDT supports such as determining if the member needs help with transportation, food, housing, WIC, employment, supplies, financial referrals, etc.
- All 15 members within the non-utilizer sample received at least one outreach attempt during the review period.
- For all NABDs reviewed, COA Region 5 used a Department template. Most NABDs also included member-specific information.
- COA Region 5 worked extensively with the State to request EPSDT services after a denial of service due to a noncovered diagnosis within one particular case reviewed. The case demonstrated detailed care coordination notes, collaboration with staff members across multiple departments and agencies involved in the members care, including Department staff members during Creative Solutions meetings. COA Region 5 made great efforts in taking the parents/family needs into consideration and ensuring proper steps were taken for getting the member placed in appropriate LOC. HSAG recognized this as a best practice in supporting the member and family.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- COA Region 5's UM EPSDT policy outlined that CM would assist with scheduling and transportation, if requested by the member/family; however, none of the NABDs reviewed for COA Region 5 included specific next steps for the member or offered assistance with scheduling appointments or transportation. Assistance offered, if any, would occur when the CM reached out to the member or parents/guardians.
- COA Region 5's policy outlined that the denial notification sent to the requesting provider includes additional information to encourage the provider to seek next steps, ensuring the provider requests the service from the correct place.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Ensure its CM staff members proactively offer assistance with scheduling appointments and transportation if the need is relevant to the member's situation. Furthermore, COA Region 5 may consider the addition of an EPSDT information flyer in applicable NABD mailings to enhance member/family awareness of available services. Additionally, HSAG suggests the addition of member-specific assistance, next steps, and offering transportation when applicable to the member's situation.
- Add additional outreach in the form of a phone call to the requesting provider before or after the issuance of the notice of denial.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- The IVR enrollment EPSDT message was robust with a great deal of information; however, the full narrative was only provided if the member answered the call and pushed the right number to authenticate that the member had been reached.
- COA Region 5 submitted multiple assessments that would be used to follow up with members that indicated SHCN; however, HSAG could not find evidence of implementation to demonstrate COA Region 5 followed up to offer services or support for SHCN as there were no risks assessments for the sample members.
- COA Region 5's Q4 FY 2021–2022 EPSDT Outreach Report indicated a 68 percent success rate but stated that, since COA Region 5 used a nonprofit mail rate, true outreach success rates were unable to be determined; therefore, letter campaigns were not assessed for success rate within the report.
- Although reaching an answering machine was considered a successful outreach by COA Region 5, the full message with EPSDT and benefit information was not left via voicemail.

- During FY 2021–2022 EPSDT quarterly outreach reporting, COA Region 5 listed IVR and letter writing as the only two outreach attempts. Email, text, and direct phone were not used during the review period.
- In one case, COA Region 5 did not use InterQual criteria, and there was limited documentation regarding medical necessity and how it made the determination from an EPSDT standpoint.
- Out of the applicable denial cases reviewed for COA Region 5, only some denial cases regarding noncovered diagnoses or services the MCE does not cover demonstrated evidence that COA Region 5 would work with the requesting provider.
- Multiple cases reviewed indicated no care coordination was offered or was not offered around the time frame of the denial.

Although these findings did not lead to recommendations, HSAG informed COA Region 5 of these findings within the report. COA Region 5 should work on addressing these findings to improve processes and procedures.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-85 presents the number of cases in the sample that HSAG reviewed for COA Region 5 and the percentage of cases in which HSAG reviewers agreed with COA Region 5's denial determination.

Table 4-85—COA Region 5 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
COA Region 5	33	33	100%

COA Region 5: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for COA Region 5:

- HSAG reviewers agreed with all COA Region 5 denial decisions.

- Out of the 33 cases reviewed, all documentation showed that COA Region 5 notified providers by various methods of communication such as live call, voicemail, email, or the provider's preferred contact method within the required time frame.
- Of the 33 cases reviewed, documentation showed that all members were sent an NABD and all 33 samples were timely.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- In 22 of the 33 sample cases, the files did not include all required content within the NABD.

To address these opportunities for improvement, HSAG recommends COA Region 5:

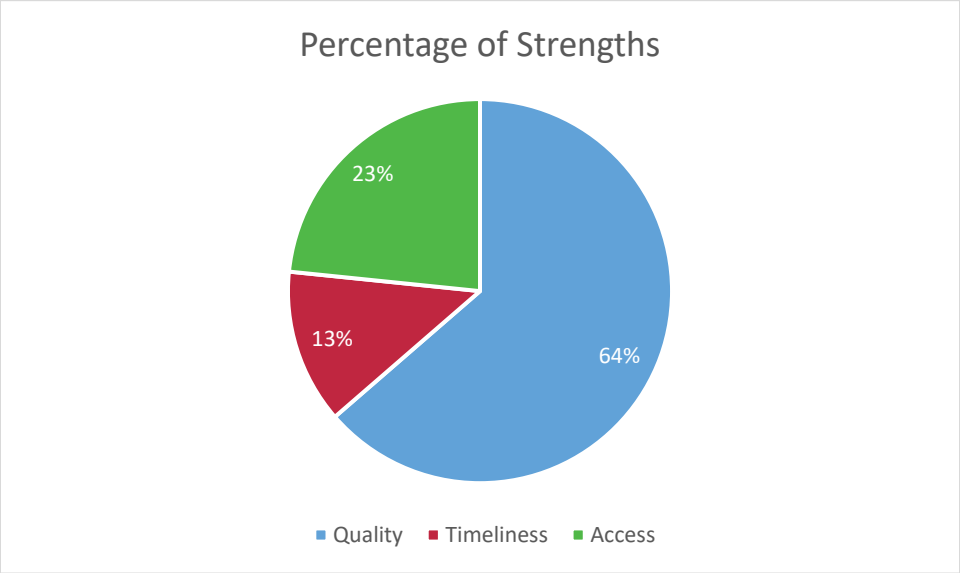
- Develop and use a NABD template to ensure that member communications regarding adverse benefit determinations include the full meaning of an acronym the first time it is used (e.g., substance use disorder [SUD], intensive outpatient [IOP], and American Society of Addiction Medicine [ASAM]) and to ensure letters contain all required content.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

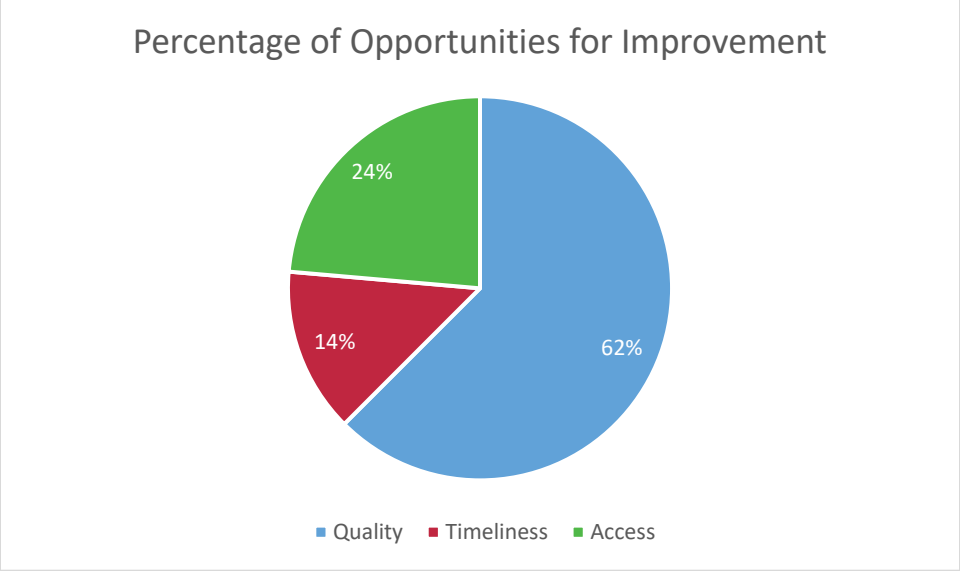
Region 6—Colorado Community Health Alliance

Figure 4-11—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 4-12—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, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, 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 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, CCHA Region 6 established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-86 and Table 4-87 summarize CCHA Region 6's PIP activities that were completed and validated in FY 2020–2021. Table 4-86 provides the SMART Aim statements that CCHA Region 6 defined for the two PIP outcome measures in Module 1.

Table 4-86—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 4-87 summarizes the preliminary key drivers and potential interventions CCHA Region 6 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-87—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

Table 4-88 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-88—Intervention Testing Plan 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*

FY 2022–2023 PIP Activities

In FY 2022–2023, CCHA Region 6 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed CCHA Region 6's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated CCHA Region 6's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for CCHA Region 6's PIP are presented in Table 4-89. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-89—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
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 of age or older.	49.27%	53.01%	58.77%	Yes
Follow-Up After a Positive Depression Screen				
The percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen administered during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older.	75.00%	93.75%	88.70%	Yes

To guide the project, CCHA Region 6 established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during an in-person or virtual outpatient primary care visit at Clinica Family Health from 49.27 percent to 53.01 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 75.00 percent to 93.75 percent, through the SMART Aim end date of June 30, 2022. CCHA Region 6's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 58.77 percent, representing a statistically significant increase of 9.5 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 88.70 percent, representing a statistically significant improvement of 13.70 percentage points over the baseline rate.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, CCHA Region 6 completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-90 summarizes CCHA Region 6's interventions described in the Module 4 PDSA

worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-90—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Identify a virtual depression screening tool (PHQ-A) 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.	Significant *clinical* improvement for *Depression Screening*	Adapted
Develop a workflow for BH referral after a positive depression screen and train Clinica staff to consistently and successfully apply the workflow to ensure members receive appropriate referral and follow-up.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

CCHA Region 6: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 developed and carried out a methodologically sound improvement project.
- CCHA Region 6 accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated achievement of the SMART Aim goal for the *Depression Screening* measure and statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure.
- The health plan's intervention testing results demonstrated clinically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-up After a Positive Depression Screen* linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, CCHA Region 6's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of CCHA Region 6's PIP, HSAG recommended:

- 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.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 PIP Recommendations

CCHA Region 6 successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-91 shows the performance measure results for CCHA Region 6 for MY 2020 through MY 2022.

Table 4-91—Performance Measure Results for CCHA Region 6

Performance Measure	MY 2020	MY 2021	MY2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	46.37%	41.61%	45.37%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	77.93%	64.51%	58.07%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	35.41%	35.30%	31.99%	48.22%
Follow-Up After a Positive Depression Screen	61.75%	47.48%	52.98%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	21.51%	17.82%	18.09%	30.56%

CCHA Region 6: Strengths

The following performance measure rates for MY 2022 increased from the previous year for CCHA Region 6:

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

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.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, CCHA Region 6 reported implementing improvement strategies for all five BHIP measures. Additionally, CCHA Region 6 reported participating in recurring meetings with other RAEs to identify and exchange information on best practices, strategize responses, and brainstorm solutions to improve performance.

CCHA Region 6 still has the opportunity to address HSAG's recommendation of creating a dashboard to monitor rates monthly or quarterly. Monitoring of rates throughout the year can help create greater visibility and timelier interventions. The ability to stratify the rates across multiple variables such as county, ZIP Code, rendering provider, etc. can help identify more targeted opportunities for improvement. CCHA Region 6 should continue to address the recommendations made by HSAG in an effort to continue to improve upon its rates.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 6 Overall Evaluation

Table 4-92 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-92—Summary of CCHA Region 6 Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	35	35	26	9	0	0	74%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**75**	**11**	**0**	**0**	**87%***

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

Table 4-93 presents the compliance scores for record reviews conducted for CCHA Region 6 during FY 2022–2023.

Table 4-93—Summary of CCHA Region 6 Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	71	64	7	29	90%
Grievances	60	57	57	0	3	100%
Appeals	60	59	50	9	1	85%
Totals	**220**	**187**	**171**	**16**	**33**	**91%***

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

CCHA Region 6: Trended Performance for Compliance With Regulations

Table 4-94 presents, for all standards, the overall percentage of compliance score for CCHA Region 6 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-94—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; 2022–2023)	**83%**	**94%**
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	**94%**	**100%**
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; 2022–2023)	**71%**	**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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

FY 2022–2023, each standard reviewed for CCHA Region 6 demonstrated high-achieving scores for three out of the four standards and improved scores for three out of the four standards when compared to the previous review year, indicating a general to strong understanding of most federal and State regulations.

CCHA Region 6: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- UM documentation expectations for UR of co-occurring and noncovered diagnoses had been expanded to include additional notes from internal staff members and requesting providers to show evidence of member-specific considerations.
- CCHA Region 6 reported increased and decreased utilization trends and presented forecasting of upcoming utilization based on expanded grants and changes after the end to the PHE.
- NABDs demonstrated an improvement in member-friendly language, particularly in the psychiatric inpatient letters.
- CCHA Region 6 implemented a new customer service software platform that includes functionality to better support the influx of calls and questions expected to occur during the PHE unwind.
- CCHA Region 6 conducted multiple trainings and shared online resources available on its website, which addressed methods for providers to clarify communications with members of different backgrounds and beliefs in order to reduce potential barriers to accessing healthcare services.
- CCHA Region 6 conducted detailed onboarding training as well as annual and monthly meetings for training opportunities to ensure it addresses all issues or questions.
- CCHA Region 6 contracted with an array of medical professionals to review special clinical cases. Each reviewer's specialties were vetted through a detailed process to ensure the specialty reviewer had the relevant credentials within the scope of the specialty clinical case.
- Grievance sample records were 100 percent compliant, and appeal sample records were 85 percent compliant.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to CCHA Region 6's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Documentation submitted by CCHA Region 6 and interviews with staff members referenced "reconsideration" of denials and "overturning" denial procedures, which do not comply with managed care regulations.
- Three out of 10 NABDs regarding ASAM LOC requests did not include all dimensions, as required, and one NABD included a diagnosis that was incorrect.
- Broomfield County met all requirements other than SUD access to care for ASAM LOC 3.3, whereas all other counties fell slightly short of time and distance standards for one or more categories: psychiatric units in acute care hospitals, general and pediatric psychiatrists, and adult primary care and family practitioners.
- The Region 6 Program Improvement Advisory Committee meeting minutes did not demonstrate a forum for oversight, monitoring, and feedback for network adequacy measures and outcomes.
- CCHA Region 6 explicitly stated the expectation for PCMPs' minimum hours of operation of 7:30 a.m. to 5:30 p.m., but it did not provide the minimum hours of 8 a.m. to 5 p.m. for behavioral health providers in documentation.
- The behavioral health provider network response rates to the CCHA Region 6 appointment surveys were low at around 10 percent during the review period.
- CCHA Region 6's *Physical Health Provider Manual* did not include as much information as the *Behavioral Health Provider Manual* regarding grievances and appeals.
- When waiting to obtain member consent during appeal procedures, staff members waited as long as possible, up until the resolution deadline, before sending an appeal resolution letter but did not utilize an extension.
- During the interview, staff members reported when grievances are received, members are asked if they would like to file a formal grievance, which is inconsistent with the definition of a grievance as "any complaint."
- One member grievance record had documentation that indicated the member called to give more information and was advised to file a new grievance on the website rather than with the representative taking down the additional information.

- CCHA Region 6's website included a downloadable PDF titled "What is the grievance and appeal process?" and the PDF included inaccurate information. Additionally, HSAG identified three out of 10 appeal acknowledgement letters that inaccurately stated a member must follow up a verbal appeal in writing.
- One out of 10 member appeal resolution letters were not timely.
- The *Member Appeals Policy* did not include that the member may file a grievance if the member disagrees with the decision to not expedite the appeal.
- CCHA Region 6 did not include extension letters or oral notice to the member in three out of 10 grievance samples.
- The appeal resolution letters only included how to request continuation of benefits by mail or fax, but not by phone.
- Provider manuals for behavioral health and physical health included two separate sections for grievances and appeals of the *Behavioral Health Provider Manual*; however, one section incorrectly combined the two processes with three bullet points that did not apply to appeals. Additionally, the "Members: Filing a Grievance" section stated that the member "must" attach documents to a grievance request, which is inconsistent with the member's right to file a grievance verbally. Lastly, the appeals sections did not include details that CCHA Region 6 will make a reasonable effort to provide oral notice of resolution for expedited appeals.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Update any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD.
- Update its NABD templates and letter writing procedure for SUD requests to include information about all dimensions.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM).
- Ensure it reviews NAV quarterly reports and annual plans with leadership for oversight, monitoring, and feedback.
- Add the minimum hours of 8 a.m. to 5 p.m. for behavioral health providers in the provider agreement, provider manual, or other similar documentation to clearly communicate the expectation with providers.
- Increase efforts to monitor the behavioral health provider network's adherence to timely appointment standards.

- Expand the *Physical Health Provider Manual* to include additional details regarding grievances and appeals, where relevant.
- Use extensions for appeals in instances where more information is needed to give the member more time.
- Enhance its messaging to members in a way that encourages members to grieve freely without the barrier of a perceived second "formal" step and conduct a refresher training that reiterates the enhanced messaging to members expressing dissatisfaction.
- Develop a refresher training on how to handle additional information received from the member during the grievance process and to enhance its monitoring of staff member documentation to ensure that representatives are accepting and reviewing additional information received from a member during an open case.
- Update the "What is the grievance and appeal process?" PDF to accurately state that a grievance acknowledgement letter will be sent to the member in two working days, remove the statement that a verbal appeal must be followed up with a written appeal, and update appeal acknowledgement letters to remove any requirement that the member must follow up a verbal appeal in writing.
- Enhance its monitoring of timeliness to ensure all appeal resolution letters are following the time frame set forth by the State contract and federal regulations.
- Update the *Member Appeals Policy* to include that the member may file a grievance.
- Enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of the member, an extension letter is sent to the member as well as prompt oral notice of the delay.
- Update the appeal resolution letters to include the contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter in regard to continuation of benefits.
- Update its *Behavioral Health Provider Manual* to clarify grievance and appeal procedures.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, CCHA Region 6 revised care coordination documents, developed a mechanism to track timeliness of provider termination notices, revised critical member materials to include taglines, ensured the accuracy and readability of the website information, and amended the EPSDT Outreach Workflow to include data processes and establish a fallout report to identify missing member populations monthly. HSAG recognizes the updates to the care coordination documents and critical member materials, as well as the development of mechanisms to track timeliness and a fallout report for quality assurance are likely to result in long-term improvements.

Validation of Network Adequacy

CCHA Region 6: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 met the minimum network requirements for General and Pediatric Behavioral Health Practitioners, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.
- While CCHA Region 6 did not meet the minimum network requirements for many provider categories across contracted counties, the requirements for which CCHA Region 6 failed to meet the minimum network requirement of 100 percent were consistently 99 to greater than 99.9 percent. For example, for Adult Primary Care Practitioners (MD, DO, NP, CNS, PA), CCHA Region 6 met the minimum network requirements in one county. However, in the four other contracted counties, access ranged from 99.8 percent to greater than 99.9 percent.
- CCHA Region 6 had match rates above 90 percent for seven out of 10 PDV indicators.

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 the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any of the contracted counties. In 60 percent of the contracted counties, access for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals ranged from 97.3 percent to 99.9 percent, and in the remaining 40 percent of counties, access ranged from 4.3 percent to 34.2 percent. 
- CCHA Region 6 did not meet the minimum network requirements for SUD Treatment Facilities across all ASAM LOCs in the contracted counties. 
- Overall, 63.3 percent of CCHA Region 6's providers could be found in the provider directory and at the sampled location. 
- CCHA Region 6 had a match rate of 83.8 percent for the street address indicator. 
- CCHA Region 6 had a match rate of 84.6 percent for the telephone number indicator. 

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Continue to conduct an in-depth review of provider categories for which CCHA Region 6 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, CCHA Region 6 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the CCHA Region 6 data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that CCHA Region 6 seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, CCHA Region 6 reported taking the following actions:

- CCHA Region 6 continued to operate an open SUD network. In addition to contracted providers, CCHA Region 6 deploys the use of SCAs to ensure there is appropriate member access as assessment and adjustment of the network unfolds.
- CCHA Region 6 worked closely with the network of providers who render SUD services to provide education on processes, notification requirements, and to minimize paperwork associated with SCAs where possible.
- CCHA Region 6 worked with community providers to expand the array of available SUD services across the care continuum to ensure member access to medically appropriate levels of service.
- CCHA Region 6 contracted with eight Psychiatric Hospitals across the state.

Based on the above response, CCHA Region 6 worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-95 presents CCHA Region 6's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-95—FY 2022–2023 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	90.5%	100.0%
Diagnosis Code	99.3%	93.4%	94.2%
Place of Service	NA	82.5%	88.3%
Service Category Modifier	NA	90.5%	100.0%
Units	NA	97.1%	96.4%
Revenue Code	100.0%	NA	NA
Discharge Status	96.4%	NA	NA
Service Start Date	100.0%	97.1%	100.0%
Service End Date	100.0%	97.1%	100.0%
Population	NA	97.1%	100.0%
Duration	NA	93.4%	96.4%
Staff Requirement	NA	94.9%	100.0%

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

Table 4-96 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 4-96—FY 2022–2023 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%
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	90.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	90.0%	100.0%	100.0%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
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 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 self-reported high overall accuracy, with 90 percent accuracy or above for all five inpatient services data elements, nine of the 10 psychotherapy services data elements, and nine of the 10 residential services data elements.
- 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 reported 100 percent agreement with three of the five inpatient services data elements, all 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:

- While the over-read results suggest confidence in CCHA Region 6's EDV results, CCHA Region 6's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with an 82.5 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

CCHA Region 6 reported assessing and enhancing its multifaceted approach to promote ongoing improvements to the accuracy of encounter data submissions. CCHA Region 6 described using website postings, a monthly News and Updates newsletter that is sent to providers, and a Behavioral Health Provider Bulletin that includes changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for its practice representatives. CCHA Region 6 also hosted a Behavioral Health Provider Open Mic Call that served as a forum to share updates and respond to providers' questions. CCHA Region 6 reported that it established a monthly Behavioral Health Provider Education Series to feature a new topic of interest, such as changes to the USCS Manual and information on the RAE 411 EDV audit. CCHA Region 6 discussed findings and scores, held mock audit exercises, and provided general education to further advance providers' familiarity, comprehension, and proficiency with audit standards and requirements. CCHA Region 6 also developed and disseminated guidelines throughout the year, as well as with the request for records, to provide additional clarity on audit requirements, common mistakes, and a self-audit checklist. Upon completion of the encounter data validation phase of the audit, practice-level scorecards with provider results were furnished to all audited providers to notify participants of their performance and to guide necessary corrections. CCHA Region 6 described how it regularly reviewed service claims to identify practices that may benefit from additional assistance. Behavioral health practice transformation coaches worked with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements and to reduce the number of denied claims. CCHA Region 6 utilized CAPs, as needed, to provide structure, clarity of expectations, and accountability for established improvement efforts.

Based on CCHA Region 6's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

CCHA Region 6: Adult CAHPS

Table 4-97 shows the adult CAHPS results for CCHA Region 6 for FY 2021–2022 and FY 2022–2023.

Table 4-97—Adult CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	56.9%	49.7% ↓
Rating of All Health Care	62.8%+	47.7% ▼
Rating of Personal Doctor	68.8%	56.8% ↓
Rating of Specialist Seen Most Often	67.1%+	56.6%+ ↓
Getting Needed Care	84.8%+	79.1%+
Getting Care Quickly	78.2%+	82.7%+
How Well Doctors Communicate	91.2%+	91.3%+
Customer Service	91.4%+	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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

CCHA Region 6: Strengths

The following measure's FY 2022–2023 score for CCHA Region 6 was higher, although not statistically significantly, than the 2022 NCQA national average:

- *Getting Care Quickly*

The following measures' FY 2022–2023 scores for CCHA Region 6 were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measures' FY 2022–2023 scores for CCHA Region 6 were statistically significantly lower than the 2022 NCQA national averages:

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

The following measure's FY 2022–2023 score for CCHA Region 6 was statistically significantly lower than the FY 2021–2022 score:

- *Rating of All Health Care*

To address these low CAHPS scores, HSAG recommends CCHA Region 6:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Consider any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with members.

CCHA Region 6: Child CAHPS

Table 4-98 shows the child CAHPS results for CCHA Region 6 for FY 2021–2022 and FY 2022–2023.

Table 4-98—Child CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	68.8%	64.2% ↓
Rating of All Health Care	68.9%	68.0%
Rating of Personal Doctor	76.5%	76.3%
Rating of Specialist Seen Most Often	83.8%+	75.9%+
Getting Needed Care	89.4%+	86.8%
Getting Care Quickly	85.4%+	87.5%
How Well Doctors Communicate	96.1%	93.8%
Customer Service	85.0%+	81.8%+

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

CCHA Region 6: Strengths

The following measures' FY 2022–2023 scores for CCHA Region 6 were higher, although not statistically significantly, than the 2022 NCQA national averages:

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

The following measure's FY 2022–2023 score for CCHA Region 6 was higher, although not statistically significantly, than the FY 2021–2022 score:

- *Getting Care Quickly*

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

The following measure's FY 2022–2023 score for CCHA Region 6 was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Health Plan*

To address these low CAHPS scores, HSAG recommends CCHA Region 6:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for parents/caretakers of child members.
- Direct parents/caretakers to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, CCHA Region 6 reported engaging in the following QI initiatives:

- CCHA quality staff reviewed results with Practice Transformation Coaches (PTCs) and providers.
  - One area identified for improvement was around practice wait times, so PTCs have been focusing on cycle times and PCMP practices to identify opportunities to increase efficiencies to keep wait times in the office down.
  - Additionally, the results indicated that care coordination for all ages and customer service for pediatrics could be improved. To address this, CCHA launched two automated surveys for members who interact with Member Support Services (call center) staff and have had a case closed after working with a care coordinator. Results from these surveys have been shared with the Member Advisory Committee (MAC), and CCHA will use ongoing data to improve care coordination workflows and processes.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that CCHA Region 6 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with CCHA Region 6.

Quality Improvement Plan

Table 4-99 presents CCHA Region 6's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-99—Summary of CCHA Region 6 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Diagnosis Code	77%	100%	100%	100%
Psychotherapy Services	Diagnosis Code	89%	100%	100%	100%
	Place of Service	86%	100%	100%	100%
Residential Services	Place of Service	77%	100%	100%	100%

**Green shading indicates accuracy of 90 percent and higher.*

CCHA Region 6: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 reached 100 percent accuracy in the QUIP for all four data elements. Most notably, the inpatient services *Diagnosis Code* and residential services *Place of Service* data elements improved from 77 percent to 100 percent in month one and maintained 100 percent accuracy throughout the intervention period.
- Key interventions throughout the QUIP included, for the inpatient services claim type, reducing the time frame for the pilot partner to finalize documentation from 30 days to two weeks; utilizing existing audit reports to notify pilot partners of delinquent charts; and providing further training to inform coders to set aside unsigned discharge summaries until they are finalized, and then populate claims forms upon receiving final updated discharged summaries.

- For the psychotherapy services claim type, CCHA Region 6 implemented updates to the EHR system software to ensure the print function includes patient identifiers and corrected and limited place of service locations to include only permitted codes.
- Lastly, for the residential services claim type, CCHA enhanced auditing capabilities to review *Place of Service* errors on a large scale, which reduced individualized efforts and helped to target investigations and aid corrective action.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- CCHA Region 6 reported that low accuracy results were due to two key failure modes: the provider and the coder. Provider issues included not documenting the diagnosis during psychiatric evaluations at time of admission, not carrying over the documented diagnosis from prior notes, and not finalizing discharge summary forms at discharge.
- Coder issues included not differentiating between preliminary and final discharge summaries, submitting *Place of Service* errors when entering manually, and inadvertently submitting errors when manually inputting patient identifiers on all pages of medical records prior to submission.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that CCHA Region 6 continue to send out news and updates monthly to providers that include specific content such as changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for practice representatives.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 QUIP Recommendations

CCHA Region 6 reported ongoing efforts to communicate to providers regarding opportunities for training that pertains to billing and coding practices. Additionally, CCHA Region 6 reported it developed and disseminated guidelines throughout the year to help provide clarity regarding audit requirements, common mistakes, and a self-audit checklist. CCHA Region 6 responded to each component of HSAG's FY 2021–2022 QUIP recommendations. HSAG recognizes that timely and consistent communication and education is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-100 displays the MHP Audit compliance scores for CCHA Region 6 for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-100—FY 2022–2023 MHP Audit Score for CCHA Region 6

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
CCHA	6	86%	Inpatient	96%	97%^
			Outpatient	99%	

^ *Indicates that the score increased as compared to the previous review year.*

CCHA Region 6: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 demonstrated an overall score of 97 percent, an 11 percentage point increase from FY 2021–2022.
- CCHA Region 6 used nationally recognized UR criteria, including MCG, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- CCHA Region 6 required UM staff members, including medical directors, to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, CCHA Region 6 reported that the last IRR testing occurred in June 2022, and all UM staff members passed with the minimum score of 90 percent or better.
- CCHA Region 6 made the denial determinations within the required time frame, and providers were notified of the denial determinations through telephone, secure email, or fax and received a copy of the NABD within the required time frame.
- In all cases reviewed, the denial determination was made by a qualified clinician, and requesting providers were offered a peer-to-peer review.
- CCHA Region 6 followed policies and procedures regarding attempting to reach out to the requesting provider for additional information due to lack of adequate documentation to determine medical necessity.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in CCHA Region 6's UM system.

- Most of CCHA Region 6's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from CCHA Region 6 when filing, access to pertinent records, and the reason for the denial. Additionally, all NABDs scored easy-to-understand reading grade levels using the Flesch-Kincaid readability test.
- During the MHP interview, CCHA Region 6 reported a best practice regarding implementation of a new care coordination referral desktop process after a previous suggestion from HSAG to ensure continuity of care after a denial determination is made during certain circumstances, such as when a member has been denied residential treatment center LOC; when a member is age 20 and under and requested benefits could fall under EPSDT; when a member has been denied SUD treatment; and when CCHA Region 6 determines that the member's needs are complex, and the member could benefit from additional support and resources.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- In three instances, CCHA Region 6 did not send the NABD to the member within the required time frame.
- While the NABDs included the required content, such as the member's appeal rights and the reason for the denial, two inpatient SUD NABDs did not include the complete list of the required ASAM dimensions and how the dimensions were considered when determining medical necessity within the NABD. Additionally, CCHA Region 6 did not include language within the *UM Program Description* about how each ASAM dimension is required in the NABD.
- Some NABDs contained Roman numerals for the ASAM dimensions and used acronyms without spelling out the meaning of the acronym the first time it was used within the NABD.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Enhance monitoring mechanisms to ensure the member is informed of the denial within the required time frame.
- Include each of the required ASAM dimensions in the inpatient SUD NABDs and continue to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA Region 6 should update the applicable document to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continue to enhance easy-to-understand language and ensure that NABDs are member-friendly, such as using numbers instead of Roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA Region 6 should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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 interpreted in the Balanced Budget Act (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.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 MHP Recommendations

CCHA Region 6 reported addressing HSAG's recommendations by:

- Implementing several process improvement activities to ensure staff member compliance with CCHA Region 6's UM policies and procedures. Process improvement activities included: creating formal desktop procedures related to clarifying diagnoses, care coordination referral processes, and peer-to peer reviews. Furthermore, CCHA Region 6 reported conducting monthly audits in which scores below 90 percent required the staff member receive coaching with UM leadership, and monthly UM associate trainings regarding desktop procedures in which attendance is mandatory.
- Outlining through a formal desktop procedure the process of creating and submitting NABDs within the contractual time frame and easy-to-understand, quarterly training regarding the formal desktop process with both the UM team and the Letters team to ensure compliance; monthly "spot checks" and audits for NABD turnaround time (TAT) with any letters that have two or more errors requiring one-on-one coaching with UM or Letter team leadership; and continued partnership with the Department in creation of resources and language (i.e., EPSDT, psychological testing, etc.) to ensure members understand UM processes, including denials, appeals, and grievances.

HSAG anticipates CCHA Region 6's response to the recommendations are likely to improve overall processes and increase its compliance score. CCHA Region 6 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

QOC Concern Audit

The QOC Concern Audit was not conducted with CCHA Region 6 in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended CCHA Region 6:

- Continue conducting staff training on the Colorado-specific QOC grievance 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 QOC grievance 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, HSAG recommended CCHA Region 6 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.

Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

CCHA Region 6 reported addressing HSAG's recommendations by:

- Updating QOC policy information to include the definition of a "QOC concern" and time frames for investigating and processing.
- Tracking member information such as race, ethnicity, and disability status for every QOC logged.
- Notifying the Department about cases posing clear clinical risks as the cases are reported. Providing updates of any corrective actions taken and case resolution.

CCHA Region 6 reported additional updates to address statewide recommendations such as:

- Providing CCHA Region 6's credentialing department with annual data per provider when a QOC concern has been substantiated (Level 3 and above).
- Updating CCHA Region 6's QOC policy to delineate that care coordinators may outreach members to determine if healthcare needs are being met.

CCHA Region 6 still has the opportunity to address HSAG's recommendation to conduct staff member training on the Colorado-specific QOC grievance process, continuing to request evidence of the CAP from a facility/provider when a CAP is initiated, and having CCHA Region 6's QM department continue to work in tandem with the grievance department to send out acknowledgement and resolution letters to members/member advocates. HSAG anticipates that CCHA Region 6's reported updates are likely to result in improvement in its QOC concern/grievance overall processes. CCHA Region 6 should continue to address the recommendations made by HSAG and continue to make updates based on guidance from the Department for upcoming contractual changes and reporting requirements.

EPSDT Audit

Table 4-101 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-101—FY 2022–2023 EPSDT Audit Findings for CCHA Region 6

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	67%	86%
Post-Denial Record Review	92%	67%	79%

CCHA Region 6: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 applied the EPSDT definition through the use of MCG guidelines and specific documentation of EPSDT considerations in the denial records reviewed, which HSAG noted to improve throughout the review period.
- The EPSDT webinar training included simplified EPSDT concepts and language such as: "extra support for children, youth, and pregnant individuals." Details included FFS provisions, procedural coding, foster care, and reinforced the "just ask" approach.

- Staff members described administering a brief assessment to investigate any benefit or resource needs when members call to initiate care, including frequently using the Community Prepared Tool related to SDOH.
- CCHA Region 6's EPSDT Data and Outreach workflow described text and IVR outreach procedures, and included additional attempt considerations for pregnant minors. The Q4 FY2021–2022 EPSDT Outreach Report showed that CCHA Region 6 used mail, IVR, and text outreach with 100 percent, 48 percent, and 97 percent success, respectively.
- Each member in the CCHA Region 6 non-utilizer sample who had not utilized services for a year prior to their enrollment anniversary date received at least one outreach attempt during the review period.
- CCHA Region 6's EPSDT policy stated that utilization is monitored in accordance with Bright Futures Guidelines. Care coordination staff members stated that members are assessed against the periodicity table for any missing services, including dental, and care support information is sent as needed.
- All CCHA Region 6's NABDs reviewed used the Department's template.
- CCHA Region 6 worked with the requesting provider to ensure the provider understood how to request the services that CCHA Region 6 does not cover in most applicable cases reviewed. Additionally, one case demonstrated CCHA Region 6's efforts to work with the State to request EPSDT services, when appropriate.
- The EPSDT policy stated that community partners (e.g., DHS, home health agencies, community-centered boards, hospitals) received updates regarding EPSDT referral procedures and referral resources at least twice annually.
- The sample denial records indicated that in instances where the member was referred to care coordination, warm handoffs were completed.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- No NABDs reviewed outlined specific next steps for the member or offered assistance with scheduling appointments and transportation.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Consider adding an EPSDT flyer to notices for members within the eligible age range that includes information about assistance with scheduling appointments and transportation.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- There were no risk assessments on file for the 15 members in the CCHA Region 6 non-utilizer sample. CCHA Region 6's Escalated Case Template demonstrated the procedure to document additional needs and agencies involved with members' treatment. However, since there were no risk assessments for the sample members in the records reviewed, HSAG could not find evidence of implementation to demonstrate CCHA Region 6 followed up to offer services or support for SHCN. 
- Staff members described the implementation of a workflow to better support members, document outreach to providers, and refer to coordination of care in cases where members needed additional support during the review period. However, in the beginning of the review period, there were inconsistencies with documentation. 
- CCHA Region 6 did not demonstrate consistent processes to outreach the provider for additional information to determine primary versus secondary diagnoses that may be driving a member's behavior, when needed. 
- In five denial cases that were applicable, only three cases indicated that CCHA Region 6 worked with the requesting provider to ensure the provider understood the service may be covered under Medicaid FFS or through EPSDT. 
- Multiple sample cases indicated that CCHA Region 6 did not refer the member to care coordination, and no care coordination services were provided to the member. 

Although these findings did not lead to recommendations, HSAG informed CCHA Region 6 of these findings within the report. CCHA Region 6 should work on addressing these findings to improve processes, procedures, and trainings.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-102 presents the number of cases in the sample that HSAG reviewed for CCHA Region 6 and the percentage of cases in which HSAG reviewers agreed with CCHA Region 6's denial determination.

Table 4-102—CCHA Region 6 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
CCHA Region 6	32	32	100%

CCHA Region 6: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 6:

- HSAG reviewers agreed with all CCHA Region 6 denial decisions.
- Within the 28 NABD letters mailed to members, each contained an explanation of the denial in language that was easy to understand, and explained the member's right to request copies for free and the right to appeals and expedited appeals.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Within the 32 NABDs that were sent to the members, only 20 were within the required time frame.
- Only two of the 28 NABD letters mailed to members included the required description of each ASAM dimension.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

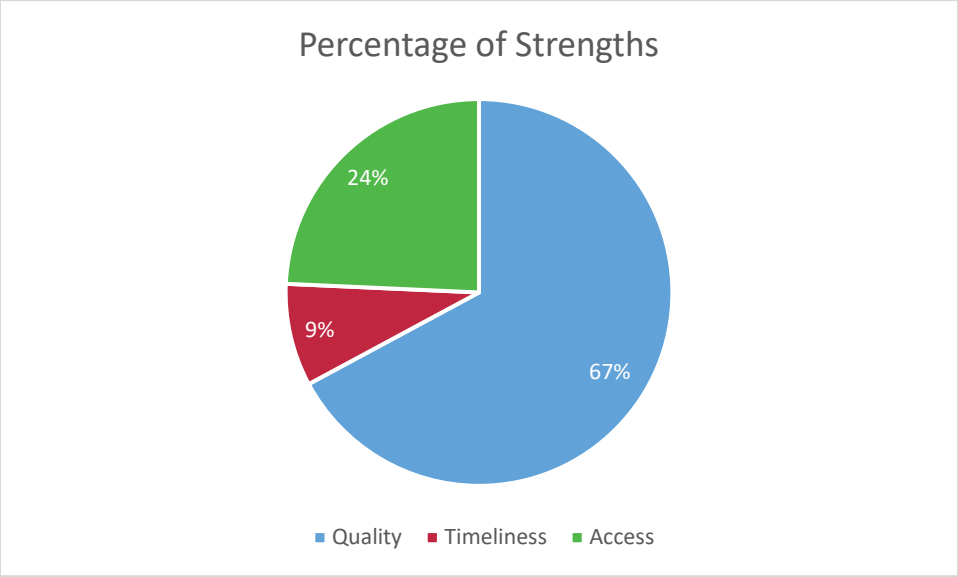
- Update policies, procedures, and processes to ensure that members and providers are notified about the denial decision in a timely manner.
- Develop and use a NABD template to ensure that member communications regarding adverse benefit determinations include a description of the medical necessity criteria and each ASAM dimension.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

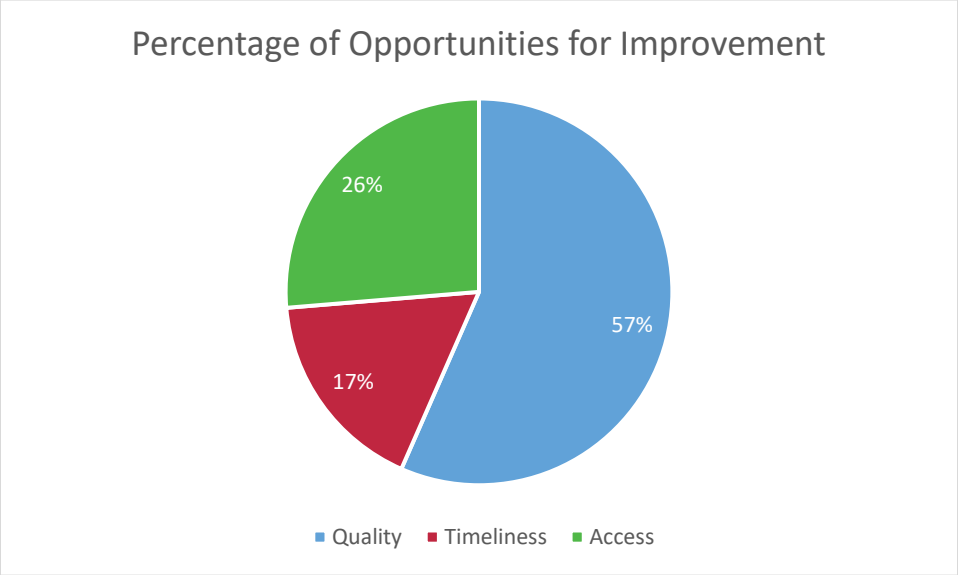
Region 7—Colorado Community Health Alliance

Figure 4-13—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 4-14—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, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, 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 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, CCHA Region 7 established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-103 and Table 4-104 summarize CCHA Region 7's PIP activities that were completed and validated in FY 2020–2021. Table 4-103 provides the SMART Aim statements that CCHA Region 7 defined for the two PIP outcome measures in Module 1.

Table 4-103—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 4-104 summarizes the preliminary key drivers and potential interventions CCHA Region 7 identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-104—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

Table 4-105 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-105—Intervention Testing Plan 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

FY 2022–2023 PIP Activities

In FY 2022–2023, CCHA Region 7 continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed CCHA Region 7's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated CCHA Region 7's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for CCHA Region 7's PIP are presented in Table 4-106. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-106—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among unduplicated CCHA Region 7 members 12 years of age or older.	62.08%	63.53%	84.05%	Yes
Follow-Up After a Positive Depression Screen				
The percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on 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 Region 7 members 12 years of age or older.	72.10%	75.74%	80.50%	Yes

To guide the project, CCHA Region 7 established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during a primary care visit at Peak Vista Community Health Centers from 62.08 percent to 63.53 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 72.10 percent to 75.74 percent, through the SMART Aim end date of June 30, 2022. CCHA Region 7's reported SMART Aim measure results demonstrated that the SMART Aim goals were exceeded for both measures. For the *Depression Screening* measure, the highest rate achieved, 84.05 percent, represented a statistically significant increase of 21.97 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 80.50 percent, represented a statistically significant increase of 8.40 percentage points above the baseline rate.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, CCHA Region 7 completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-107 summarizes CCHA Region 7's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-107—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Revise Peak Vista's depression screening (Patient Health Questionnaire-9 [PHQ-9]) script to guide providers in educating patients on the benefits of depression screening and help motivate members to complete the screening. The electronic health record (EHR) depression screening forms were also adapted to capture member refusals and medical exclusions more consistently.	Significant *clinical* improvement for *Depression Screening*	Adopted
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.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence.*

CCHA Region 7: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 developed and carried out a methodologically sound improvement project.
- CCHA Region 7 accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated achievement of the SMART Aim goals and statistically significant improvement over baseline performance for both the *Depression Screening* measure and the *Follow-Up After a Positive Depression Screen* measure.
- CCHA Region 7's intervention testing results demonstrated clinically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, CCHA Region 7 final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of CCHA Region 7's PIP, HSAG recommended:

- 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.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 PIP Recommendations

CCHA Region 7 successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Performance Measure Rates and Validation

Table 4-108 shows the performance measure results for CCHA Region 7 for MY 2020 through MY 2022.

Table 4-108—Performance Measure Results for CCHA Region 7

Performance Measure	MY 2020	MY 2021	MY 2022	MY 2022 Performance Target
Engagement in Outpatient SUD Treatment	46.37%	54.10%	61.25%	51.00%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	77.93%	41.42%	32.49%	87.58%
Follow-Up Within 7 Days of an ED Visit for SUD	35.41%	32.75%	31.97%	48.22%
Follow-Up After a Positive Depression Screen	61.75%	73.39%	64.85%	67.93%
Behavioral Health Screening or Assessment for Children in the Foster Care System	21.51%	23.29%	16.06%	30.56%

CCHA Region 7: Strengths

The following performance measure rate for MY 2022 increased from the previous year for CCHA Region 7:

- *Engagement in Outpatient SUD Treatment*

Additionally, the following performance measure rate for MY 2022 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*

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*
- *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 7:

- Create a dashboard to monitor rates monthly or quarterly.
- Consider implementing a data quality dashboard to routinely monitor the accuracy, completeness, and timeliness of the data used to inform performance measure calculation.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 Performance Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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, setting up reminders for members to ensure the follow-up visit occurs.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 Performance Measure Recommendations

Based on the recommendations provided by HSAG, CCHA Region 7 reported implementing improvement strategies for all five BHIP measures. Additionally, CCHA Region 7 reported participating in recurring meetings with other RAEs to identify and exchange information on best practices, strategize responses, and brainstorm solutions to improve performance.

CCHA Region 7 still has the opportunity to address HSAG's recommendation of creating a dashboard to monitor rates monthly or quarterly. Monitoring of rates throughout the year can help create greater visibility and timelier interventions. The ability to stratify the rates across multiple variables such as county, ZIP Code, rendering provider, etc. can help identify more targeted opportunities for improvement. CCHA Region 7 should continue to address the recommendations made by HSAG in an effort to continue to improve upon its rates.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 7 Overall Evaluation

Table 4-109 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-109—Summary of CCHA Region 7 Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	35	35	26	9	0	0	74%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**75**	**11**	**0**	**0**	**87%***

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

Table 4-110 presents the compliance scores for record reviews conducted for CCHA Region 7 during FY 2022–2023.

Table 4-110—Summary of CCHA Region 7 Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	74	70	4	26	95%
Grievances	60	55	55	0	5	100%
Appeals	60	58	49	9	2	84%
Totals	**220**	**187**	**174**	**13**	**33**	**93%***

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

CCHA Region 7: Trended Performance for Compliance With Regulations

Table 4-111 presents, for all standards, the overall percentage of compliance score for CCHA Region 7 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-111—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, 2022–2023)	**87%**	**94%**
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	**94%**	**100%**
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, 2022–2023)	**74%**	**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 and Applicable Review Years*	CCHA Region 7 Average—Previous Review	CCHA Region 7 Average—Most Recent Review**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***Grey shading indicates standards for which no previous comparison results are available.*
****NA indicates the first year of reviewing the standard.*

FY 2022–2023, each standard reviewed for CCHA Region 7 demonstrated high-achieving scores for three out of the four standards and improved scores for three out of the four standards when compared to the previous year, indicating a general to strong understanding of most federal and State regulations.

CCHA Region 7: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- UM documentation expectations for UR of co-occurring and noncovered diagnoses had been expanded to include additional notes from internal staff members and requesting providers to show evidence of member-specific considerations.
- CCHA Region 7 reported increased and decreased utilization trends and presented forecasting of upcoming utilization based on expanded grants and changes after the end to the PHE.
- NABDs demonstrated an improvement in member-friendly language, particularly in the psychiatric inpatient letters.
- CCHA Region 7 implemented a new customer service software platform that includes functionality to better support the influx of calls and questions expected to occur during the PHE unwind.
- CCHA Region 7 conducted multiple trainings and shared online resources available on its website, which addressed methods for providers to clarify communications with members of different backgrounds and beliefs in order to reduce potential barriers to accessing healthcare services.
- CCHA Region 7 conducted detailed onboarding training as well as annual and monthly meetings for training opportunities to ensure it addresses all issues or questions.

- CCHA Region 7 contracted with an array of medical professionals to review special clinical cases. Each reviewer's specialties were vetted through a detailed process to ensure the specialty reviewer had the relevant credentials within the scope of the specialty clinical case.
- Grievance sample records were 100 percent compliant, and appeal sample records were 84 percent compliant.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to CCHA Region 7's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Documentation submitted by CCHA Region 7 and interviews with staff members referenced "reconsideration" of denials and "overturning" denial procedures, which do not comply with managed care regulations.
- Three out of 10 NABDs regarding ASAM LOC requests did not include all dimensions, as required, and one NABD included a diagnosis that was incorrect.
- El Paso County reported 98 percent access, whereas Teller County reported 40 percent access and Park County only 6 percent access. All three counties struggled with SUD treatment access time and distance standards.
- The Region 7 Program Improvement Advisory Committee meeting minutes did not demonstrate a forum for oversight, monitoring, and feedback for network adequacy measures and outcomes.
- CCHA Region 7 explicitly stated the expectation for PCMPs' minimum hours of operation of 7:30 a.m. to 5:30 p.m., but it did not provide the minimum hours of 8 a.m. to 5 p.m. for behavioral health providers in documentation.
- The behavioral health provider network response rates to the CCHA Region 7 appointment surveys were low at around 10 percent during the review period.
- CCHA Region 7's *Physical Health Provider Manual* did not include as much information as the *Behavioral Health Provider Manual* regarding grievances and appeals.

- When waiting to obtain member consent during appeal procedures, staff members waited as long as possible, up until the resolution deadline, before sending an appeal resolution letter but did not utilize an extension.
- During the interview, staff members reported when grievances are received, members are asked if they would like to file a formal grievance, which is inconsistent with the definition of a grievance as "any complaint."
- CCHA Region 7's website included a downloadable PDF titled "What is the grievance and appeal process?" and the PDF included inaccurate information. Additionally, language included in the appeal acknowledgement letters inaccurately stated a member must follow up a verbal appeal in writing.
- CCHA Region 7 sent late appeal acknowledgment letters in two out of 10 files.
- Two out of 10 appeal acknowledgment letters did not state the correct time frame in which the member would receive the decision of the appeal request.
- One out of 10 member appeal resolution letters were not timely.
- The *Member Appeals Policy* did not include that the member may file a grievance if the member disagrees with the decision to not expedite the appeal.
- CCHA Region 7 did not include extension letters or oral notice to the member in one out of 10 grievance requests.
- The appeal resolution letters only included how to request continuation of benefits by mail or fax but not by phone.
- Provider manuals for behavioral health and physical health included two separate sections for grievances and appeals of the *Behavioral Health Provider Manual*; however, one section incorrectly combined the two processes with three bullet points that did not apply to appeals. Additionally, the "Members: Filing a Grievance" section stated that the member "must" attach documents to a grievance request, which is inconsistent with the member's right to file a grievance verbally. Lastly, the appeals sections did not include details that CCHA Region 7 will make a reasonable effort to provide oral notice of resolution for expedited appeals.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Update any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD.

- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM).
- Ensure it reviews NAV quarterly reports and annual plans with leadership for oversight, monitoring, and feedback.
- Add minimum hours of 8 a.m. to 5 p.m. for behavioral health providers in the provider agreement, provider manual, or other similar documentation to clearly communicate the expectation with providers.
- Increase efforts to monitor the behavioral health provider network's adherence to timely appointment standards.
- Expand the *Physical Health Provider Manual* to include additional details, where relevant.
- Use extensions in instances where more information is needed to give the member more time.
- Enhance its messaging to members in a way that encourages members to grieve freely without the barrier of a perceived second "formal" step and conduct a refresher training that reiterates the enhanced messaging to members expressing dissatisfaction.
- Develop a refresher training on how to handle additional information received from the member during the grievance process and to enhance its monitoring of staff member documentation to ensure that representatives are accepting and reviewing additional information received from a member during an open case.
- Update the "What is the grievance and appeal process?" PDF to accurately state that a grievance acknowledgement letter will be sent to the member in two working days, remove the statement that a verbal appeal must be followed up with a written appeal, and update appeal acknowledgement letters to remove any requirement that the member must follow up a verbal appeal in writing.
- Enhance monitoring of appeal acknowledgment timeliness to ensure it is meeting the time frame set forth by the State contract and federal regulations.
- Ensure all appeal acknowledgment letters accurately identify the correct time frame for the resolution of an appeal.
- Enhance its monitoring of timeliness to ensure all appeal resolution letters are following the time frame set forth by the State contract and federal regulations.
- Updated the *Member Appeals Policy* to include that the member may file a grievance.
- Enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of the member, an extension letter is sent to the member as well as prompt oral notice of the delay.
- Update the appeal resolution letters to include the contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter in regard to continuation of benefits.
- Update its *Behavioral Health Provider Manual* to clarify grievance and appeal procedures.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, CCHA Region 7 revised care coordination documents, developed a mechanism to track timeliness of provider termination notices, revised critical member materials to include taglines, ensured the accuracy and readability of the website information, and amended the EPSDT Outreach Workflow to include data processes and establish a fallout report to identify missing member populations monthly. HSAG recognizes the updates to the care coordination documents and critical member materials, as well as the development of mechanisms to track timeliness and a fallout report for quality assurance are likely to result in long-term improvements.

Validation of Network Adequacy

CCHA Region 7: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 met the minimum network requirements for General and Pediatric Behavioral Health Practitioners as well as General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties, across urbanicity.
- In the contracted urban counties for which CCHA Region 7 did not meet minimum network requirements for Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA), Family Practitioners (MD, DO, NP, CNS, PA), and General and Pediatric SUD Treatment Practitioners, access ranged from 99 to greater than 99.9 percent of the minimum network requirements for all listed provider categories.
- Based on the PDV results, strengths were not identified for CCHA Region 7.

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 the minimum network requirements for SUD Treatment Facilities across all ASAM LOCs, or for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in all contracted counties, across county designation.
- CCHA Region 7 did not meet the minimum network requirements for Adult Primary Care Practitioners (MD, DO, NP, CNS) or Family Practitioners (MD, DO, NP, CNS) in all contracted urban and rural counties. Additionally, CCHA Region 7 did not meet the minimum network requirements for Adult Primary Care Practitioners (PA), Family Practitioners (PA), or Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA) in 66.6 percent of contracted counties, across urbanicity.
- Overall, only 51.8 percent of CCHA Region 7's providers could be found in the directory and at the sampled location.
- CCHA Region 7 had a match rate of 82.6 percent for the street address indicator.
- CCHA Region 7 had a match rate of 85.9 percent for the telephone number indicator.
- CCHA Region 7 had a match rate of 87.2 percent for the practitioner gender indicator.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Continue to conduct an in-depth review of provider categories for which CCHA Region 7 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, CCHA Region 7 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the CCHA Region 7 data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that CCHA Region 7 seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, CCHA Region 7 reported taking the following actions:

- CCHA Region 7 continued to operate an open SUD network. In addition to contracted providers, CCHA deploys the use of SCAs to ensure there is appropriate member access as assessment and adjustment of the network unfolds.
- CCHA Region 7 worked closely with the network of providers who render SUD services to provide education on processes, notification requirements, and to minimize paperwork associated with SCAs where possible.
- CCHA Region 7 worked with community providers to expand the array of available SUD services across the care continuum to ensure member access to medically appropriate levels of service.
- CCHA Region 7 contracted with eight Psychiatric Hospitals across the state.

Based on the above response, CCHA Region 7 worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-112 presents CCHA Region 7's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-112—FY 2022–2023 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	91.2%	98.5%
Diagnosis Code	97.1%	90.5%	92.0%
Place of Service	NA	81.8%	90.5%
Service Category Modifier	NA	91.2%	98.5%
Units	NA	97.1%	96.4%
Revenue Code	100.0%	NA	NA
Discharge Status	55.5%	NA	NA
Service Start Date	97.8%	97.1%	97.8%
Service End Date	98.5%	97.1%	98.5%
Population	NA	97.1%	98.5%
Duration	NA	94.9%	96.4%
Staff Requirement	NA	92.7%	98.5%

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

Table 4-113 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 4-113—FY 2022–2023 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%
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	90.0%	100.0%
Service Category Modifier	NA	100.0%	90.0%
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%	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	90.0%	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 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 self-reported high overall accuracy, with 90 percent accuracy or above for four of the five inpatient services data elements, nine of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- 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 reported 100 percent agreement with four of the five inpatient services data elements, eight of the 10 psychotherapy services data elements, and nine of the 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in CCHA Region 7's EDV results, CCHA Region 7's self-reported EDV results for the *Discharge Status* data element for inpatient services demonstrated a low level of encounter data accuracy, with a 55.5 percent accuracy rate when compared to the corresponding medical records.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended 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.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

CCHA Region 7 reported assessing and enhancing its multifaceted approach to promote ongoing improvements to the accuracy of encounter data submissions. CCHA Region 7 described using website postings, a monthly News and Updates newsletter that is sent to providers, and a Behavioral Health Provider Bulletin that includes changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for its practice representatives. CCHA Region 7 also hosted a Behavioral Health Provider Open Mic Call that served as a forum to share updates and respond to providers' questions. CCHA Region 7 reported that it established a monthly Behavioral Health Provider Education Series to feature a new topic of interest, such as changes to the USCS manual and information on the RAE 411 EDV audit. CCHA Region 7 discussed findings and scores, held mock audit exercises, and provided general education to further advance providers' familiarity, comprehension, and proficiency with audit standards and requirements. CCHA Region 7 also developed and disseminated guidelines throughout the year, as well as with the request for records, to provide additional clarity on audit requirements, common mistakes, and a self-audit checklist. Upon completion of the encounter data validation phase of the audit, practice-level scorecards with provider results were furnished to all audited providers to notify participants of their performance and to guide necessary corrections. CCHA Region 7 described how it regularly reviewed service claims to identify practices that may benefit from additional assistance. Behavioral health practice transformation coaches worked with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements and to reduce the number of denied claims. CCHA Region 7 utilized CAPs, as needed, to provide structure, clarity of expectations, and accountability for established improvement efforts.

Based on CCHA Region 7's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

CCHA Region 7: Adult CAHPS

Table 4-114 shows the adult CAHPS results for CCHA Region 7 for FY 2021–2022 and FY 2022–2023.

Table 4-114—Adult CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	48.2%	51.1% ↓
Rating of All Health Care	49.0%+	50.5%+
Rating of Personal Doctor	55.7%	62.0%
Rating of Specialist Seen Most Often	72.6%+	68.8%+
Getting Needed Care	80.8%+	81.1%+
Getting Care Quickly	77.5%+	80.9%+
How Well Doctors Communicate	92.8%+	93.7%+
Customer Service	92.2%+	82.6%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

CCHA Region 7: Strengths

The following measures' FY 2022–2023 scores for CCHA Region 7 were higher, although not statistically significantly, than the 2022 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

Every measure's FY 2022–2023 score for CCHA Region 7, except *Rating of Specialist Seen Most Often* and *Customer Service,* was higher, although not statistically significantly, than the FY 2021–2022 score.

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

The following measure's FY 2022–2023 score for CCHA Region 7 was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Health Plan*

To address these low CAHPS scores, HSAG recommends CCHA Region 7:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

CCHA Region 7: Child CAHPS

Table 4-115 shows the child CAHPS results for CCHA Region 7 for FY 2021–2022 and FY 2022–2023.

Table 4-115—Child CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	66.1%	58.1% ↓
Rating of All Health Care	61.9%	54.8% ↓
Rating of Personal Doctor	75.0%	69.2% ↓
Rating of Specialist Seen Most Often	62.2%+	72.0%+
Getting Needed Care	70.6%+	73.9%+ ↓
Getting Care Quickly	83.6%+	78.5%+ ↓

Measure	FY 2021–2022 Score	FY 2022–2023 Score
How Well Doctors Communicate	94.0%	89.6% ↓
Customer Service	86.8%+	85.0%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

CCHA Region 7: Strengths

The following measures' FY 2022–2023 scores for CCHA Region 7 were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

Every measure's FY 2022–2023 score for CCHA Region 7, except *Rating of Specialist Seen Most Often* and *Customer Service*, was statistically significantly lower than the 2022 NCQA national average.

To address these low CAHPS scores, HSAG recommends CCHA Region 7:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with parents/caretakers of child members.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, CCHA Region 7 reported engaging in the following QI initiatives:

- CCHA quality staff reviewed results with PTCs and providers.
  - One area identified for improvement was around practice wait times, so PTCs have been focusing on cycle times and PCMP practices to identify opportunities to increase efficiencies to keep wait times in the office down.
  - Additionally, the results indicated that care coordination for all ages and customer service for pediatrics could be improved. To address this, CCHA launched two automated surveys for members who interact with Member Support Services (call center) staff and have had a case closed after working with a care coordinator. Results from these surveys have been shared with the MAC, and CCHA will use ongoing data to improve care coordination workflows and processes.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that CCHA Region 7 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with CCHA Region 7.

Quality Improvement Plan

Table 4-116 presents CCHA Region 7's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-116—Summary of CCHA Region 7 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Discharge Status	58%	100%	100%	100%
Psychotherapy Services	Place of Service	84%	100%	100%	100%
Residential Services	Place of Service	83%	100%	100%	100%

**Green shading indicates accuracy of 90 percent and higher.*

CCHA Region 7: Strengths

Based on QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 had baseline scores that were overall not far under 90 percent accuracy for two of the three data elements for the QUIP.
- All three data elements reached 100 percent accuracy in month one and maintained 100 percent accuracy in months two and three. Most notably, the inpatient services *Discharge Status* data element significantly improved from 58 percent to 100 percent.
- Key interventions throughout the QUIP for the inpatient services claim type included the pilot partner correcting software to ensure accurate transfers of the disposition to the claim form and conducting audits of discharge summaries for status code accuracy.
- For the psychotherapy services claim type, interventions included conducting training as part of onboarding and continuing education for all staff members regarding documentation and how to verify location, as well as performing random audits on documentation to verify the accuracy of training.
- Lastly, for the residential services claim type, interventions included reviewing the backend system map to identify and correct the "Type of Bill" drop down field procedure code for better accuracy.

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 low accuracy results were due to the patient accounting software, which did not transfer the disposition type entered in the discharge summary to the claim form; clinicians inaccurately entering the location in the progress note; and the billing department overriding all service claims to telehealth due to office closures and no in-person services being provided at the time.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that CCHA Region 7 continue to send out news and updates monthly to providers that include specific content such as changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for practice representatives.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 QUIP Recommendations

CCHA Region 7 reported ongoing efforts to communicate to providers regarding opportunities for training that pertains to billing and coding practices. Additionally, CCHA Region 7 reported it developed and disseminated guidelines throughout the year to help provide clarity regarding audit requirements, common mistakes, and a self-audit checklist. CCHA Region 7 responded to each component of HSAG's FY 2021–2022 QUIP recommendations. HSAG recognizes that timely and consistent communication and education is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-117 displays the MHP Audit compliance scores for CCHA Region 7 for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-117—FY 2022–2023 MHP Audit Score for CCHA Region 7

RAE	Region	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD Services					
CCHA	7	81%	Inpatient	90%	92%^
			Outpatient	93%	

^ *Indicates that the score increased as compared to the previous review year.*

CCHA Region 7: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 demonstrated an overall score of 92 percent, an 11 percentage point increase from FY 2021–2022.
- CCHA Region 7 used nationally recognized UR criteria, including MCG, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- CCHA Region 7 required UM staff members, including medical directors, to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, CCHA Region 7 reported

that the last IRR testing occurred in June 2022, and all UM staff members passed with the minimum score of 90 percent or better.

- In all cases reviewed, the denial determination was made by a qualified clinician.
- CCHA Region 7 followed policies and procedures regarding attempting to reach out to the requesting provider for additional information due to lack of adequate documentation to determine medical necessity.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in CCHA Region 7's UM system.
- CCHA Region 7's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from CCHA Region 7 when filing, access to pertinent records, and the reason for the denial.
- During the MHP interview, CCHA Region 7 reported a best practice regarding implementation of a new care coordination referral desktop process after a previous suggestion from HSAG to ensure continuity of care after a denial determination is made during certain circumstances, such as when a member has been denied residential treatment center LOC; when a member is age 20 and under and requested benefits could fall under EPSDT; when a member has been denied SUD treatment; and when CCHA Region 7 determines that the member's needs are complex, and the member could benefit from additional support and resources.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- In multiple records reviewed, CCHA Region 7 did not notify the provider of the denial determination, and the NABD was not sent to the member within the required time frame.
- In one instance, CCHA Region 7 did not offer a peer-to-peer review.
- While the NABDs included the required content, such as the member's appeal rights and the reason for the denial, two inpatient SUD NABDs did not include the complete list of the required ASAM dimensions and how the dimensions were considered when determining medical necessity within the NABD. Additionally, CCHA Region 7 did not include language within the *UM Program Description* about how each ASAM dimension is required in the NABD.
- Some NABDs contained Roman numerals for the ASAM dimensions and used acronyms without spelling out the meaning of the acronym the first time it was used within the NABD.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.
- Follow establish policies and procedures to ensure requesting providers are consistently offered peer-to-peer review. Additionally, HSAG recommends revising the *UM Program Description* document to ensure consistency between CCHA Region 7's written policies, program descriptions, and organizational processes.
- Include each of the required ASAM dimensions in the inpatient SUD NABDs and continue to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA Region 7 should update the applicable documents to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continue to enhance easy-to-understand language and ensure that NABDs are member-friendly, such as using numbers instead of Roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA Region 7 should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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 interpreted 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.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 MHP Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by:

- Implementing several process improvement activities to ensure staff member compliance with CCHA Region 7's UM policies and procedures. Process improvement activities included: creating formal desktop procedures related to clarifying diagnoses, care coordination referral processes, and peer-to peer reviews. Furthermore, CCHA Region 7 reported conducting monthly audits in which scores below 90 percent required the staff member receive coaching with UM leadership, and monthly UM associate trainings regarding desktop procedures in which attendance is mandatory.

- Outlining through a formal desktop procedure the process of creating and submitting NABDs within the contractual time frame and easy-to-understand, quarterly training regarding the formal desktop process with both the UM team and the Letters team to ensure compliance; monthly "spot checks" and audits for NABD TAT with any letters that have two or more errors requiring one-on-one coaching with UM or Letter team leadership; and continued partnership with the Department in creation of resources and language (i.e., EPSDT, psychological testing, etc.) to ensure members understand UM processes, including denials, appeals, and grievances.

HSAG anticipates CCHA Region 7's response to the recommendations are likely to improve overall processes and increase its compliance score. CCHA Region 7 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

QOC Concern Audit

The QOC Concern Audit was not conducted with CCHA Region 7 in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended CCHA Region 7:

- Continue conducting staff training on the Colorado-specific QOC grievance 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 QOC grievance 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, HSAG recommended CCHA Region 7 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.

Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by:

- Updating QOC policy information to include the definition of a "QOC concern" and time frames for investigating and processing.
- Tracking member information such as race, ethnicity, and disability status for every QOC logged.
- Notifying the Department about cases posing clear clinical risks as the cases are reported. Providing updates of any corrective actions taken and case resolution.

CCHA Region 7 reported additional updates to address statewide recommendations such as:

- Providing CCHA Region 7's credentialing department with annual data per provider when a QOC concern has been substantiated (Level 3 and above).
- Updating CCHA Region 7's QOC policy to delineate that care coordinators may outreach members to determine if healthcare needs are being met.

CCHA Region 7 still has the opportunity to address HSAG's recommendation to conduct staff member training on the Colorado-specific QOC grievance process, continuing to request evidence of the CAP from a facility/provider when a CAP is initiated, and having CCHA Region 7's QM department continue to work in tandem with the grievance department to send out acknowledgement and resolution letters to members/member advocates. HSAG anticipates that CCHA Region 7's reported updates are likely to result in improvement in its QOC concern/grievance overall processes. CCHA Region 7 should continue to address the recommendations made by HSAG and continue to make updates based on guidance from the Department for upcoming contractual changes and reporting requirements.

EPSDT Audit

Table 4-118 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-118—FY 2022–2023 EPSDT Audit Findings for CCHA Region 7

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	67%	86%
Post-Denial Record Review	92%	50%	73%

CCHA Region 7: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 applied the EPSDT definition through the use of MCG guidelines and specific documentation of EPSDT considerations in the denial records reviewed, which HSAG noted to improve throughout the review period.
- The EPSDT webinar training included simplified EPSDT concepts and language such as: "extra support for children, youth, and pregnant individuals." Details included FFS provisions, procedural coding, foster care, and reinforced the "just ask" approach.
- Staff members described administering a brief assessment to investigate any benefit or resource needs when members call to initiate care, including frequently using the Community Prepared Tool related to SDOH.
- CCHA Region 7's EPSDT Data and Outreach workflow described text and IVR outreach procedures, and included additional attempt considerations for pregnant minors. The Q4 FY2021–2022 EPSDT Outreach Report showed that CCHA Region 7 used mail, IVR, and text outreach with 100 percent, 44 percent, and 97 percent success, respectively.
- Each member in the CCHA Region 7 non-utilizer sample who had not utilized services for a year prior to their enrollment anniversary date received at least one outreach attempt during the review period.
- CCHA Region 7's EPSDT policy stated that utilization is monitored in accordance with Bright Futures Guidelines. Care coordination staff members stated that members are assessed against the

periodicity table for any missing services, including dental, and care support information is sent as needed.

- All CCHA Region 7's NABDs reviewed used the Department's template.
- The EPSDT policy stated that community partners (e.g., DHS, home health agencies, community-centered boards, hospitals) received updates regarding EPSDT referral procedures and referral resources at least twice annually.
- The sample denial records demonstrated that in instances where the member was referred to care coordination, warm handoffs were completed in all but one case.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- No NABDs reviewed outlined specific next steps for the member or offered assistance with scheduling appointments and transportation.
- CCHA Region 7 did not work with the requesting provider to ensure the provider understood how to request the services CCHA Region 7 does not cover within the applicable cases; however, documentation showed that care coordinators made an effort to outreach the requesting provider and/or parents/guardians to help coordinate services for members.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Consider adding an EPSDT flyer to notices for members within the eligible age range that includes information about assistance with scheduling appointments and transportation.
- Enhance efforts to refer between UM and care coordination, especially for noncovered services.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- There were no risk assessments on file for the 15 members in the CCHA Region 7 non-utilizer sample. CCHA Region 7's Escalated Care Template demonstrated the procedure to document additional needs and agencies involved with members' treatment. However, since there were no risk assessments for the sample members in the records reviewed, HSAG could not find evidence of implementation to demonstrate CCHA Region 7 followed up to offer services or support for SHCN.
- Staff members described the implementation of a workflow to better support members, document outreach to providers, and refer to coordination of care in cases where members needed additional

support during the review period. However, in the beginning of the review period, there were inconsistencies with documentation.

- CCHA Region 7 did not demonstrate consistent processes to outreach the provider for additional information to determine primary versus secondary diagnoses that may be driving a member's behavior, when needed.
- Multiple sample cases demonstrated that CCHA Region 7 did not refer the member to care coordination, or there was no care coordination involvement, whether CCHA Region 7 provided care coordination services or the Accountable Care Network (i.e., PeakVista).
- Within one case, UM system notes indicated the member was to be referred to a recommended alternative LOC. However, there was no indication that the referral was completed and tracked by care coordination staff members, or any warm handoff was provided to ensure the member followed up with the recommended alternative LOC.

Although these findings did not lead to recommendations, HSAG informed CCHA Region 7 of these findings within the report. CCHA Region 7 should work on addressing these findings to improve processes, procedures, and trainings.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-119 presents the number of cases in the sample that HSAG reviewed for CCHA Region 7 and the percentage of cases in which HSAG reviewers agreed with CCHA Region 7's denial determination. HSAG received 18 cases; however, one of the cases was withdrawn by the provider and, therefore, was removed from the sample.

Table 4-119—CCHA Region 7 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
CCHA Region 7	18	17[1]	100%

[1] Due to one sample being not applicable, the total applicable sample is 17.

CCHA Region 7: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for CCHA Region 7:

- HSAG reviewers agreed with all CCHA Region 7 denial decisions.
- Within the 16 NABDs mailed to members, each contained an explanation of the denial in language that was easy to understand, and explained the member's right to request copies for free, the right to appeals and expedited appeals, and the medical necessity criteria used to make the determination.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Within the 16 NABDs that were sent to the members, only eight were within the required time frame.
- None of the 16 NABDs included the required description of ASAM dimensions.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Update policies, procedures, and processes to ensure that members and providers are notified about the denial decision in a timely manner.
- Develop and use a NABD template to ensure that member communications regarding adverse benefit determinations include a description of each ASAM dimension.

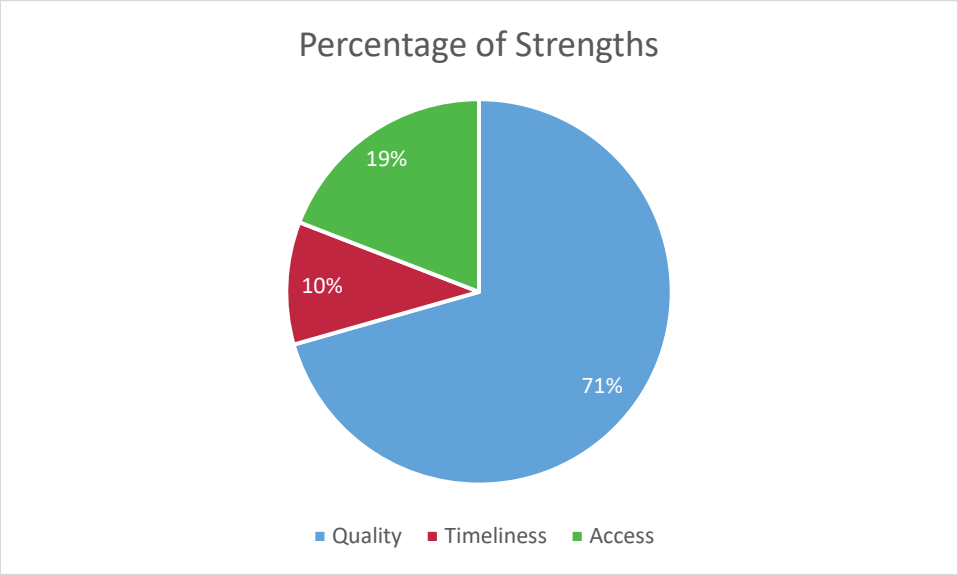
Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

Managed Care Organizations

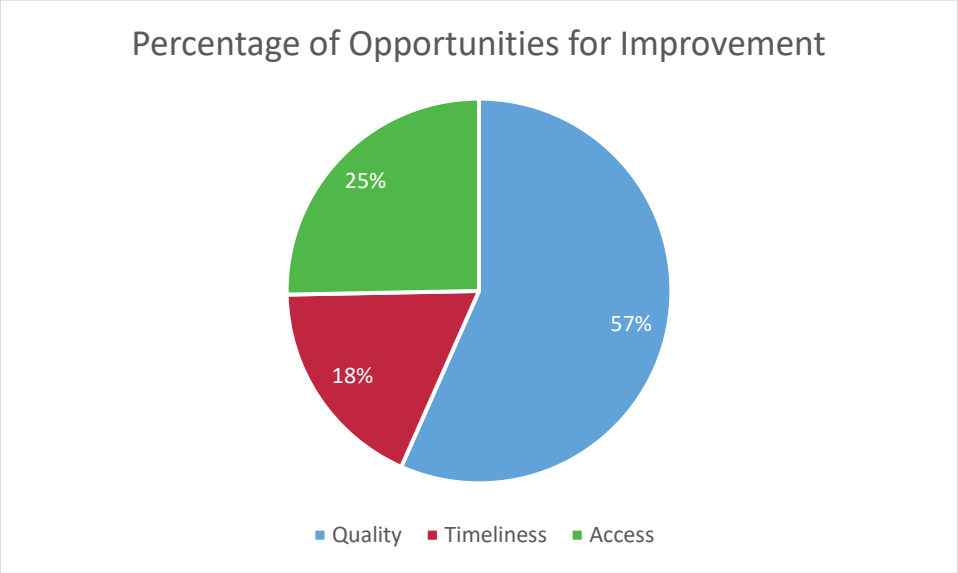
Denver Health Medical Plan

Figure 4-15—Percentage of Strengths by Care Domain for DHMP*



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

Figure 4-16—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, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, DHMP established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-120 and Table 4-121 summarize DHMP's PIP activities that were completed and validated in FY 2020–2021. Table 4-120 provides the SMART Aim statements that DHMP defined for the two PIP outcome measures in Module 1.

Table 4-120—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 58.95%.

**The SMART Aim statement was revised in February 2022. HSAG approved revisions to the SMART Aim statement in February 2022 in response to DHMP's correction of data queries used to produce the baseline percentage and goal.*

Table 4-121 summarizes the preliminary key drivers and potential interventions DHMP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-121—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.

Table 4-122 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-122—Intervention Testing Plan 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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
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

FY 2022–2023 PIP Activities

In FY 2022–2023, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed the initial Module 4 submission form, provided initial feedback to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

HSAG analyzed DHMP's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated DHMP's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for DHMP's PIP are presented in Table 4-123. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-123—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members ages 12–21 years assigned to the Westside Pediatrics PCMH.	65.86%	68.86%	69.48%	*Yes*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
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 ages 12–21 years assigned to the Westside Pediatrics PCMH.	47.89%	58.95%	54.05%	*No*

To guide the project, DHMP established goals of increasing the percentage of members 12 through 21 years of age assigned to Westside Pediatrics PCMH who received an annual depression screening from 65.86 percent to 68.86 percent and increasing the percentage of those members who received BH services within 30 days of screening positive for depression from 47.89 percent to 58.95 percent, through the SMART Aim end date of June 30, 2022. DHMP's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 69.48 percent, representing a statistically significant increase of 3.62 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 54.05 percent, representing an improvement of 6.16 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, DHMP completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-124 summarizes DHMP's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-124—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Expand depression screening services to all primary care acute (sick) visits in addition to well visits.	Significant *programmatic* and *clinical* improvement for *Depression Screening*	Adopted
Same-day warm handoff to in-clinic BH provider when a member screens positive for depression.	Significant *programmatic* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

DHMP: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP developed and carried out a methodologically sound improvement project.
- DHMP accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure and improvement over baseline performance that was not statistically significant for the *Follow-Up After a Positive Depression Screen* measure.
- DHMP's intervention testing results demonstrated clinically significant improvement for *Depression Screening* and programmatically significant improvement for both measures linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, DHMP's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of DHMP's PIP, HSAG recommended:

- 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.

Assessment of DHMP's Approach to Addressing FY 2021–2022 PIP Recommendations

DHMP successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

HEDIS/Core Set Measure Rates and Validation

DHMP: Information Systems Standards Review

According to the HEDIS MY 2022 FAR, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted DHMP's performance measure reporting.

DHMP: Performance Measure Results

Table 4-125 shows the performance measure results for DHMP for MY 2020 through MY 2022, along with the percentile ranking for each MY 2022 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 2022 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Table 4-125—Performance Measure Results for DHMP

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
Ages 52 to 64 Years[H]	—	41.70%	46.91%^	BTSA
Ages 65 to 74 Years[H]	—	30.96%	35.82%	WTSA
Cervical Cancer Screening				
Cervical Cancer Screening[H]	41.11%	39.36%	34.24%	<10th

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	47.04%	51.55%	52.97%	25th–49th
Ages 12 to 17 Years[H]	39.88%	43.56%	45.59%	25th–49th
Ages 18 to 21 Years[H]	14.79%	15.70%	15.57%	<10th
Total[H]	39.31%	41.93%	42.90%	10th–24th
Childhood Immunization Status				
DTaP[H]	69.47%	65.93%	75.25%^	50th–74th
IPV[H]	82.19%	75.71%	85.59%^	25th–49th
MMR[H]	84.04%	76.87%	85.69%^	50th–74th
HiB[H]	81.93%	77.20%	84.69%^	50th–74th
Hepatitis B[H]	85.09%	74.40%	88.77%^	50th–74th
VZV[H]	83.68%	76.92%	85.39%^	50th–74th
Hepatitis A[H]	82.54%	77.25%	85.29%^	75th–89th
Pneumococcal Conjugate[H]	74.21%	68.13%	77.04%^	75th–89th
Rotavirus[H]	63.77%	60.22%	64.71%^	25th–49th
Influenza[H]	50.26%	52.09%	53.78%	50th–74th
Combination 3[H]	67.98%	61.92%	72.47%^	75th–89th
Combination 7[H]	57.81%	53.08%	59.64%^	75th–89th
Combination 10[H]	40.18%	40.22%	42.05%	50th–74th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	67.65%	76.77%	77.04%	≥90th
Ages 21 to 24 Years[H]	66.95%	68.54%	70.33%	≥90th
Colorectal Cancer Screening				
Ages 46 to 49 Years[H]	—	—	14.01%	WTSA
Ages 50 to 64 Years[H]	—	—	27.05%	WTSA
Ages 65 Years and Older[H]	—	—	32.99%	WTSA
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	—	48.58%	BTSA
2 Years[SA]	—	—	75.82%	WTSA
3 Years[SA]	—	—	58.92%	BTSA
Total[SA]	—	—	60.80%	BTSA
Immunizations for Adolescents				
Meningococcal[H]	78.25%	66.58%	72.22%^	10th–24th
Tdap[H]	77.64%	66.73%	74.52%^	10th–24th
HPV[H]	46.79%	37.04%	37.19%	50th–74th
Combination 1[H]	75.70%	64.92%	71.77%^	10th–24th
Combination 2[H]	45.11%	35.93%	36.84%	50th–74th

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Lead Screening in Children				
Lead Screening in Children[H]	—	—	61.16%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	65.85%	71.29%	**68.01%^^**	10th–24th
BMI Percentile—Ages 12 to 17 Years[H]	64.61%	68.96%	68.21%	10th–24th
BMI Percentile—Total[H]	65.36%	70.33%	68.09%	10th–24th
Counseling for Nutrition—Ages 3 to 11 Years[H]	72.33%	77.17%	74.96%	50th–74th
Counseling for Nutrition—Ages 12 to 17 Years[H]	66.10%	70.31%	70.43%	50th–74th
Counseling for Nutrition—Total[H]	69.85%	74.36%	73.10%	50th–74th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	71.63%	76.45%	73.78%	50th–74th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	65.49%	69.87%	69.36%	25th–49th
Counseling for Physical Activity—Total[H]	69.19%	73.75%	71.96%	50th–74th
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%	58.28%	50th–74th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	57.13%	54.42%	59.29%^	10th–24th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	—	20.68%	WTSA
MMEC—Ages 21 to 44 Years[SA]	—	—	18.89%	WTSA
LARC—Ages 15 to 20 Years[SA]	—	—	5.30%	WTSA
LARC—Ages 21 to 44 Years[SA]	—	—	4.95%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	—	25.68%	BTSA
MMEC—3 Days—Ages 21 to 44 Years[SA]	—	—	27.59%	BTSA
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	—	59.46%	WTSA
MMEC—90 Days—Ages 21 to 44 Years[SA]	—	—	56.40%	BTSA
LARC—3 Days—Ages 15 to 20 Years[SA]	—	—	6.76%	BTSA
LARC—3 Days—Ages 21 to 44 Years[SA]	—	—	10.21%	BTSA
LARC—90 Days—Ages 15 to 20 Years[SA]	—	—	27.03%	WTSA
LARC—90 Days—Ages 21 to 44 Years[SA]	—	—	25.91%	BTSA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	83.36%	79.51%	77.26%	10th–24th
Postpartum Care[H]	69.22%	70.66%	69.45%	10th–24th

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	56.73%	62.50%	<10th
Ages 12 to 18 Years[H]	—	64.38%	53.49%	<10th
Total (Ages 5 to 18 Years)[H]	—	59.89%	58.05%	BTSA
Ages 19 to 50 Years[H]	—	47.01%	51.71%	10th–24th
Ages 51 to 64 Years[H]	—	48.57%	52.50%	10th–24th
Total (Ages 19 to 64 Years)[H]	—	47.38%	51.91%	WTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	95.41%	—	96.52%	≥90th
Ages 18 to 64 Years[H]	61.46%	—	68.26%	≥90th
Ages 65 Years and Older[H]	NA	—	NA	—
Concurrent Use of Opioids and Benzodiazepines				
Ages 18 to 64 Years[,SA]*	—	—	5.74%	BTSA
Ages 65 Years and Older[,SA]*	—	—	6.52%	BTSA
Controlling High Blood Pressure				
Ages 18 to 64 Years[H]	—	48.54%	47.93%	BTSA
Ages 65 to 85 Years[H]	—	55.92%	56.64%	BTSA
HbA1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Ages 18 to 64 Years[H]	—	—	44.94%	BTSA
HbA1c Control (<8.0%)—Ages 65 to 75 Years[H]	—	—	51.44%	BTSA
Poor HbA1c Control (>9.0%)—Ages 18 to 64 Years[*,H]*	—	—	45.15%	BTSA
Poor HbA1c Control (>9.0%)—Ages 65 to 75 Years[*,H]*	—	—	37.77%	BTSA
HIV Viral Load Suppression				
Ages 18 to 64 Years[SA]	—	—	NA	—
Ages 65 Years and Older[SA]	—	—	NA	—
Use of Opioids at High Dosage in Persons Without Cancer				
Ages 18 to 64 Years[,SA]*	—	—	5.04%	WTSA
Ages 65 Years and Older[,SA]*	—	—	4.88%	BTSA
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	—	47.54%	47.15%	10th–24th
Antidepressant Medication Management				
Effective Acute Phase Treatment—Ages 18 to 64 Years[H]	—	64.50%	66.37%^	BTSA
Effective Acute Phase Treatment—Ages 65 Years and Older[H]	—	78.00%	76.92%	WTSA
Effective Continuation Phase Treatment—Ages 18 to 64 Years[H]	—	42.55%	46.53%	BTSA

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Effective Continuation Phase Treatment—Ages 65 Years and Older[H]	—	72.00%	53.85%	BTSA
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)				
Ages 18 to 64 Years[*,H]*	—	—	53.93%	BTSA
Ages 65 to 75 Years[*,H]*	—	—	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 Medication[H]	—	86.68%	85.52%	75th–89th
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	9.30%	<10th
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	21.44%	16.74%	<10th
7-Day Follow-Up—65 Years and Older[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	25.58%	<10th
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	29.02%	24.17%	<10th
30-Day Follow-Up—65 Years and Older[H]	—	NA	NA	—
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	17.65%	—
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	20.78%	—
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	14.89%	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	23.53%	—
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	28.33%	—
30-Day Follow-Up—Ages 65 Years and Older[H]	—	—	21.28%	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	8.54%	2.47%	<10th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	15.85%	17.28%	<10th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	41.28%	30.95%	38.89%	25th–49th
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Alcohol—Ages 18 to 64 Years[H]	—	—	40.11%	—
Initiation of SUD Treatment—Alcohol—Ages 65 Years and Older[H]	—	—	56.76%	—
Initiation of SUD Treatment—Opioid—Ages 18 to 64 Years[H]	—	—	50.81%	—
Initiation of SUD Treatment—Opioid—Ages 65 Year and Older[H]	—	—	60.00%	—

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Initiation of SUD Treatment—Other Drug—Ages 18 to 64 Years[H]	—	—	40.10%	—
Initiation of SUD Treatment—Other Drug—Ages 65 Years and Older[H]	—	—	NA	—
Initiation of SUD Treatment—Total—Ages 18 to 64 Years[H]	—	—	41.59%	—
Initiation of SUD Treatment—Total—Ages 65 Years and Older[H]	—	—	58.24%	—
Engagement of SUD Treatment—Alcohol—Ages 18 to 64 Years[H]	—	—	6.63%	—
Engagement of SUD Treatment—Alcohol—Ages 65 Years and Older[H]	—	—	3.60%	—
Engagement of SUD Treatment—Opioid—Ages 18 to 64 Years[H]	—	—	15.50%	—
Engagement of SUD Treatment—Opioid—Ages 65 Years and Older[H]	—	—	13.33%	—
Engagement of SUD Treatment—Other Drug—Ages 18 to 64 Years[H]	—	—	4.57%	—
Engagement of SUD Treatment—Other Drug—Ages 65 Years and Older	—	—	NA	—
Engagement of SUD Treatment—Total—Ages 18 to 64 Years[H]	—	—	7.07%	—
Engagement of SUD Treatment—Total—Ages 65 Years and Older[H]	—	—	4.71%	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	—	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	56.25%	NA	NA	—
Blood Glucose Testing—Total[H]	50.00%	NA	NA	—
Cholesterol Testing—Ages 1 to 11 Years[H]	—	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	50.00%	NA	NA	—
Cholesterol Testing—Total[H]	47.22%	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	—	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	40.63%	NA	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	36.11%	NA	NA	—
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[SA]	—	—	34.14%	BTSA
Ages 18 to 64 Years[SA]	—	—	18.40%	BTSA
Ages 65 Years and Older[SA]	—	—	6.26%	BTSA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	NA	NA	—
Total[H]	—	NA	NA	—
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	—	—	51.62%	WTSA
Rate 2: Buprenorphine[SA]	—	—	48.70%	BTSA
Rate 3: Oral Naltrexone[SA]	—	—	1.95%	WTSA

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Rate 4: Long-Acting, Injectable Naltrexone[SA]	—	—	1.62%	BTSA
Rate 5: Methadone[SA]	—	—	0.32%	WTSA
Use of Services				
Ambulatory Care: Emergency Department Visits				
*<1 Year**[,SA]	—	23.94	773.59	—
*Ages 1 to 9 Years**[,SA]	—	19.62	376.07	—
*Ages 10 to 19 Years**[,SA]	—	54.09	253.56	—
*Total (Ages 0 to 19 Years)**[, H]	—	22.47	317.11	—
PQI 01: Diabetes Short-Term Complications Admission Rate				
*Ages 18 to 64 Years**[,SA]	—	—	16.69	—
*Ages 65 Years and Older**[,SA]	—	—	0.00	—
PQI 05: COPD or Asthma in Older Adults Admission Rate				
*Ages 40 to 64 Years**[,SA]	—	—	20.13	—
*Ages 65 Years and Older**[,SA]	—	—	43.95	—
PQI 08: Heart Failure Admission Rate				
*Ages 18 to 64 Years**[,SA]	—	—	24.10	—
*Ages 65 Years and Older**[,SA]	—	—	1,385.48	—
PQI 15: Asthma in Younger Adults Admission Rate				
*Ages 18 to 39 Years**[,SA]	—	—	3.50	—
Plan All-Cause Readmissions				
Observed Readmissions[H]	11.35%	9.51%	9.54%	—
Expected Readmissions[H]	—	9.63%	9.49%	—
*O/E Ratio**[,H]	1.14	0.99	1.0051	—
Outlier Rate[H]	—	—	49.41	—

**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.
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 there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2021 to MY 2022.

DHMP: Strengths

The following required HEDIS MY 2022 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 2021, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2021):

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Ages 18 to 64 Years*
- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *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*

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

The following required HEDIS MY 2022 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 2021):

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* and *Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years* and *Ages 18 to 64 Years*, and *30-Day Follow-Up—Ages 6 to 17 Years* and *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*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

To address these low measure rates, HSAG recommends DHMP:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the MCOs consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS/Core Set Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended 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 serious 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]

[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: Dec 5, 2023.

- 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.[4-2]

Assessment of DHMP's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

Based on the recommendations provided by HSAG, DHMP reported implementing the following:

- Expanded its active partnership and collaboration in QI workgroup activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, and annual visits. Workgroups were established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal and postpartum, integrated behavioral health, transitions of care, immunizations, and ambulatory care QIC.
- Partnered in a collaborative work with the QI director of ACS and ACS QI staff to build out joint QI interventions, including shared data analytics.
- For the measures related to well-child visits, EPSDT, and immunizations, DHMP reported implementing the following interventions:
  - Enhanced efforts continued for wraparound services outside of the health plan, and for tracking of referrals for services outside the health plan, by network providers. Additionally, improved the number of EPSDT services tracked at ACS, available by clinic and provider.
  - Distributed Healthy Hero Birthday Cards, which were sent to members ages 19 and under, that provided a checklist with information on healthy eating, development, vaccines, and physical activity. The birthday cards were 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 included how to schedule a well-child appointment. For SFY 2022–2023, DHMP mailed an average of 1,435 birthday cards a month to Medicaid Choice members and an average of 105 birthday cards a month to CHP+ members.
  - Began using text messages sent three days before a well-child appointment for ages 3 and older to the parent/guardian on file to remind them of their child's upcoming important well-child visit. DHMP also sent important paperwork through MyChart for families to review and fill out prior to the appointment to facilitate a smoother check-in process and better information sharing.
  - Began making phone calls to parents/guardians when a child has missed a well-child visit at 1, 2, 4, and 6 months within 24 hours of the missed appointment to help them reschedule. This helps keep families on track for important visits, screenings, and immunizations in the first year of life.
  - Continued the use of school-based health centers (SBHCs): Denver Health Medicaid Choice and CHP+ members. SBHCs provided a variety of services such as well-child visits, sport physicals, immunizations, chronic disease management, primary care, and BH services. DHMP continues to encourage eligible members to access care through the network of SBHCs. This information

[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: Dec 5, 2023.

was sent directly to member households in newsletters and was also available on its website. In addition, the appointment center used a process that alerted schedulers of SBHC-enrolled students, which sends prompts to schedule the children at an SBHC for their clinic needs. Additionally, students could directly schedule an appointment at their SBHC through their MyChart account.

- For the *Breast Cancer Screening* measure, DHMP reported implementing the following interventions:
  - Distributed monthly mammogram mailers to members due for mammography screening. The mailer included information on scheduling an appointment as well as a link to a calendar for the women's mobile clinic, which allowed members to schedule a mammogram at their home clinic and avoid travel to the Denver Health and Hospital Authority (DHHA) main campus. DHMP sent mammogram reminder mailers to 6,826 female Medicaid members between July 1, 2022, and June 30, 2023.
- For measures related to asthma interventions, DHMP reported implementing the following interventions:
  - The Asthma Work Group and RN line utilized a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. Members were also informed about the need to make an asthma assessment appointment with their PCPs if they have refilled their rescue medication without refilling the appropriate number of controller medications.
  - Continued to utilize DHHA patient navigators (PNs) to conduct follow-up phone calls within 48 hours of discharge from the ED or an inpatient stay for pediatric members with an asthma-related concern. PNs were tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a transition of care flowsheet.
- For the measures related to access to care, DHMP reported implementing the following interventions:
  - DHMP continued to operate 18 SBHCs that provide healthcare in an easy and convenient setting to all plan members who attend Denver Public Schools.
  - Several strategies were developed to reduce the wait list, including an improved new patient workflow for the Appointment Center, the hiring and placement of providers in key locations, collaboration between the Appointment Center and clinics to fill open appointment slots, and adjusted provider panel sizes. Saturday morning hours for primary care at three locations have continued at the Montbello Health Center, Denver Health main campus, and at the Westside Family Health Center on Federal Boulevard.
  - 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, ancillary care, and hospital services. The Denver Health Member Handbook contains information on member benefits and how to access care within the DHMP network.

- Distributed a welcome packet to new members that included their ID card and Quick Reference Guide. DHMP also provides orientation videos in English and Spanish on the website for members. These videos informed its members about their benefits and provided information on how the plan works.
- DHMP maintained a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine was capable of discussing the members' symptoms and concerns, assisting members in understanding the urgency of their needs, and helping members decide 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 could write prescriptions for some illnesses and could also schedule a Dispatch Health visit.
- DHMP continued 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. DHMP has expanded the use of Dispatch Health to include skilled nursing facility at home, hospital at home, and bridging services to assist in early discharges.
- Continued to use MyChart, which is a user-friendly application/website with multiple capabilities available to members to enhance and support their experiences. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, reviewing lab results, communicating directly with providers, and a providing a centralized location for tracking health outcomes and programs. It was used to send mass messages about the availability of COVID-19 and flu vaccines. as requirements changed rapidly.
- Began utilizing an e-consult process that allowed providers to refer members for an e-consult with a specialist who can review the case and provide recommendations for care without, in many cases, having to see the member for a visit. E-consults are generally acted on within three business days. This resulted in less wait times for specialty access. In the event that a follow-up visit was needed, the specialty provider can order a visit.
- Continued to offer telehealth visits for members. Members can schedule telehealth visits, including urgent care, via MyChart.
- Continued to contract with STRIDE Community Health Center. The partnership added 15 additional clinic locations (three of which have pharmacies on-site) and options for members.

DHMP reported strong member-, provider-, and community-facing interventions targeted to improve the quality of care and timely access to healthcare services. Additionally, DHMP was able to demonstrate strong partnerships and collaboration with the community and provider network to engage across all service levels exhibiting extensive commitment and efforts for continuous improvement. HSAG recommends evaluating the effectiveness of the interventions and the observed impact the interventions have on performance rates. This includes but is not limited to evaluating the percentage of members who received mailers and birthday cards that resulted in a rendered service. Lastly, based on the effectiveness of the intervention, determine the sustainability and spread plan to target other service types that may benefit from these types of interventions.

Assessment of Compliance With Medicaid Managed Care Regulations

DHMP Overall Evaluation

Table 4-126 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-126—Summary of DHMP Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	33	33	32	1	0	0	97%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	28	7	0	0	80%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**87**	**87**	**78**	**9**	**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.*

Table 4-127 presents the compliance scores for record reviews conducted for DHMP during FY 2022–2023.

Table 4-127—Summary of DHMP Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	68	58	10	32	85%
Grievances	60	51	51	0	9	100%
Appeals	60	54	53	1	6	98%
Totals	**220**	**173**	**162**	**11**	**47**	**94%***

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

DHMP: Trended Performance for Compliance With Regulations

Table 4-128 presents, for all standards, the overall percentage of compliance score for DHMP for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-128—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; 2022–2023)	**97%**	**97%**
Standard II—Adequate Capacity and Availability of Services (2016–2017; 2019–2020; 2022–2023)	**87%**	**92%**
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; 2022–2023)	**83%**	**80%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA****	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***NA indicates the first year of reviewing the standard.*

In FY 2022–2023, DHMP demonstrated consistent moderate to high-achieving scores and improvement from the previous review year for two of the four standards reviewed. Standard I—Coverage and Authorization of Services demonstrated consistent high-achieving scores, Standard II—Adequate Capacity and Availability of Services demonstrated improvement by 5 percentage points from the previous review year, and Standard XII—Enrollment and Disenrollment demonstrated an overall high-achieving score. However, Standard VI—Grievance and Appeal Systems declined by 3 percentage points compared to the previous review.

DHMP: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for DHMP:

- IRR testing most recently occurred in August 2022, and staff members reported that the passing rate was 97 percent.
- The *DHHA Annual Training* included topics related to cultural competency such as embracing diversity, ensuring inclusion, maximizing positive interactions with members and their caregivers/family, and other methods to ensure members feel "comfortable, cared for, and valued." Staff members described ongoing targeted efforts for lesbian, gay, bisexual, transgender, and queer, criminal justice, foster care, and refuge members, and the training addressed ways to support members with body type diversity to ensure correctly sized medical equipment.
- When a provider filed an appeal on behalf of a member, in addition to sending a written acknowledgement letter to the member, DHMP verbally contacted the provider to request additional documents and inform the provider that documents can be submitted via Epic Systems Corporation's online system.
- Grievance and appeal notices were written at approximately a sixth-grade reading level. DHMP consistently met the timeliness requirements for grievance acknowledgement and resolution notices as well as for appeal resolution letters. DHMP's MCO grievance record reviews showed 100 percent compliance. DHMP demonstrated strong monitoring over grievances and appeals and conducted regular committee meetings to discuss issues.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to DHMP's system with no restriction.

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

HSAG found the following opportunities for improvement:

- Policy language included a definition of "medical necessity" across multiple documents; however, it did not fully detail extension procedures or NABD procedures.
- Some NABDs included language that may be confusing to the member such as "not a covered benefit" when the denial is solely regarding out-of-network requests.
- The NABD included language to the member, "You may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us. Your doctor can discuss this decision with our Medical Doctor by calling us." This language conflicts

with the intent of the requirement, which is to complete the peer-to-peer consultation *prior* to making the denial decision and notifying the member.

- NABD templates did not demonstrate consistently updated information and did not always incorporate the date the appeal is due. There were instances in which references indicated that the member must submit a signed copy of an appeal. The template did not contain language informing members that they may receive a copy of their file, at no cost, upon request or that a State fair hearing may be requested within 120 days from the adverse appeal resolution. DHMP has an opportunity to include information to clarify that peer-to-peer reviews after issuance of the NABD will occur as part of the appeal process and to insert denial decision dates in headings rather than using the terminology "Effective Date of Denial."
- ASAM LOC 3.3 had particularly low compliance with access standards, whereas LOCs 3.7 and 3.7 WM were reported having 93 percent to 94 percent compliance in FY 2022–2023 Q1.
- Network reports detailed ongoing data issues with member addresses that resulted in a portion (roughly 1,000 members, less than 1 percent) of the network reporting as *Not Met* or *Not Reported* due to records placing the member outside of the contracted region after geocoding. In 85 percent of these cases, DHMP reported that data suggest the address is accurate, but the county is incorrect.
- The Provider Access Survey presentation from CY 2022 Q3 indicated that contracted providers had low compliance with timely appointments.
- The DHMP Medicaid (MCD) member handbook included physical health appointment timeliness content but did not include behavioral health appointment timeliness standards. Additionally, the *Network Plan* incorrectly stated that urgently needed services are available within 48 hours of being requested by the member or the member's provider(s).
- The appeal process stated the accurate time frame for a member to file an appeal, set by the State. However, it also stated that a specialist would write the member's appeal and send it with the acknowledgement letter, and the member is required to sign and return the written appeal within 10 working days. This procedure is inconsistent with the federal updates that no longer require an appeal to be submitted in writing.
- One appeal sample did not include a written acknowledgement letter.
- The "Medicaid Choice Grievance and Appeals" section on its website and the MCO's NABDs did not include that information would be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.
- The Medicaid website stated the incorrect time frame for expedited resolutions.

- DHMP's appeal acknowledgement and resolution templates did not include accurate information about the continuation of benefits during a State fair hearing.
- The provider manual and Medicaid website did not accurately include information stating if a State fair hearing decision overturns the denial, DHMP must provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.
- The provider manual included inaccurate information about the time frames of a decision regarding an expedited appeal, State fair hearing, appeal request, continuation of benefits request, and the end of the service authorization related to continuation of benefits during a State fair hearing.

To address these opportunities for improvement, HSAG recommends DHMP:

- Update policies to include a cohesive definition of "medical necessity" with all ASAM and EPSDT definitions, and clarify extension procedures and NABD procedures.
- Update NABD template language to remove language that may be confusing to the member such as "not a covered benefit" when the denial is solely regarding out-of-network requests.
- Clarify that any peer-to-peer conversations after the issuance of an NABD must occur through the appeal process. When appropriate, staff members should outreach the requesting provider to attempt to obtain additional clinical information prior to making an authorization decision and prior to notifying the member regarding the denial.
- Update its NABD templates to ensure accurate information and must develop a process to ensure that the updated NABD is used consistently.
- Continue working with COA and the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.3, 3.7, and 3.7 WM).
- Enhance ongoing conversations with the Department to improve data accuracy to monitor the DHMP network more clearly against eligible members in the applicable counties.
- Reintroduce CAPs to providers with low compliance with timely appointment standards when the focus of larger efforts begins to move away from the COVID-19 PHE.
- Update its MCD member handbook to include behavioral health appointment timeliness standards and its *Network Plan* to include the 24-hour urgent care timeliness requirement.
- Remove any language from its appeal process that requires the member to sign and return a written appeal.
- Ensure that timely written acknowledgement letters for appeals are sent even when a member withdraws an expedited appeal and it is downgraded to a standard appeal.

- Update its NABDs and the Medicaid website to inform the member or member's representative that information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.
- Update the website sections about expedited appeals to reflect the accurate time frame of 72 hours set forth by federal and State regulation.
- Update its appeal acknowledgement and resolution templates to state that *both* the State fair hearing and continuation of benefits must be requested within 10 days of the appeal resolution letter not in the member's favor.
- Update the "Continuation of Benefits" section of its Medicaid website and the "Effectuation of Appeal Resolutions" section of the provider manual to state that DHMP will provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.
- Update the provider manual to include the time frame of a decision regarding an expedited appeal, State fair hearing, appeal request, continuation of benefits request, and clarify that the end of the service authorization does not impact continuation of benefits during a State fair hearing.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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.

Assessment of DHMP's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, DHMP revised critical member materials to include full taglines in prominent locations and developed mechanisms to ensure all member informational documents were within the sixth-grade reading level to the extent possible. Additionally, DHMP updated the Medicaid Choice member handbook to be consistent with the State and federal definitions and to state, upon member request, it would be printed and mailed within five business days. HSAG recognizes the updates to the critical member materials and monitoring printing requests are likely to result in long-term improvements.

Validation of Network Adequacy

DHMP: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP met all minimum network requirements for General and Pediatric Behavioral Health Practitioners as well as General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.
- DHMP met minimum network requirements for Adult Primary Care Practitioners (MD, DO, NP, CNS), Pediatric Primary Care Practitioners (MD, DO, NP, CNS), and Family Practitioners (MD, DO, NP, CNS) in 75 percent of contracted counties. However, for the specified provider categories for which DHMP did not meet the minimum network requirements, access was greater than 99.9 percent.
- Based on the PDV results, strengths were not identified for DHMP.

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 the minimum network requirements for SUD Treatment Facilities across all ASAM LOCs in all contracted counties. While most ASAM LOCs for which DHMP has not met the minimum network requirements report access levels of 98 percent to greater than 99.9 percent, DHMP struggled particularly with ASAM LOC 3.3, with rates of access at 0 percent in all contracted counties.
- While DHMP did not meet the minimum network requirements for a number of General and Pediatric Specialty provider categories, it should be noted that the level of access for all affected provider categories was greater than 99 percent.
- Overall, 54.5 percent of DHMP's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 33.3 percent were found at the sampled location. While DHMP utilizes COA's online provider directory for the Medicaid MCO line of business, and COA noted that providers participating with a CMHC or other treatment center are not listed individually in the online provider directory, these providers are listed individually in the DHMP's provider data, resulting in a high rate of mismatched data for this indicator.
- DHMP had a match rate of 44.5 percent for the practitioner type/specialty indicator.
- DHMP had a match rate of 65.7 percent for the telephone number indicator.

- At only 2.9 percent, DHMP had the second lowest match rate for the accepting new patients indicator. However, new patient acceptance information is missing from the COA online provider directory, which is utilized by DHMP's members for the Medicaid MCO line of business.
- At 26.3 percent, DHMP had the lowest match rate for the practitioner gender indicator.

To address these opportunities for improvement, HSAG recommends DHMP:

- Continue to conduct an in-depth review of provider categories for which DHMP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, DHMP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure DHMP's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.
- DHMP utilizes the COA directory for BH providers contracted with its Medicaid MCO line of business, but not for its CHP+ MCO line of business. MCEs with different names that share online provider directories could cause confusion or belief that a member is not utilizing the correct online provider directory. As such, DHMP could consider using its own provider directory for all lines of business.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that DHMP seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of DHMP's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, DHMP reported taking the following actions:

- To support providers, DHMP maintained the 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 reported exploring improvements and upgrades to bring in additional features.
- DHMP continued to engage Department staff members in conversations around challenges with members that reside outside of the DHMP service area.
- DHMP contracts with COA to facilitate behavioral health services. COA is dedicated to contracting with every willing state-validated provider to become part of the network, regardless of their location, provided they meet the credentialing and contracting criteria. Building on the foundation of the existing statewide BH/SUD network, COA continued to use various resources to further target potential additions and grow the network of providers. COA has a dedicated provider contracting team that responds to inquiries and requests to participate in the network.

Based on the above response, DHMP worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—DHMP 411 Audit Over-Read

Table 4-129 presents DHMP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-129—FY 2022–2023 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	83.2%	97.1%
Diagnosis Code	84.7%	92.7%	100.0%
Place of Service	NA	86.9%	100.0%
Service Category Modifier	NA	83.2%	97.1%
Units	NA	96.4%	100.0%
Revenue Code	97.1%	NA	NA
Discharge Status	92.0%	NA	NA
Service Start Date	95.6%	96.4%	99.3%
Service End Date	97.1%	96.4%	98.5%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Population	NA	96.4%	100.0%
Duration	NA	94.9%	100.0%
Staff Requirement	NA	87.6%	100.0%

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

Table 4-130 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 4-130—FY 2022–2023 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	90.0%	100.0%
Diagnosis Code	90.0%	100.0%	90.0%
Place of Service	NA	90.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	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	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 411 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP self-reported high overall accuracy, with 90 percent accuracy or above for four of the five inpatient services data elements, six of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- 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 three of the five inpatient services data elements, eight of the 10 psychotherapy services data elements, and nine of the 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:

- While the over-read results suggest confidence in DHMP's EDV results, DHMP's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with an 83.2 percent accuracy rate for the *Procedure Code* and *Service Category Modifier* data elements when compared to the corresponding medical records.

To address these 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.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended DHMP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of DHMP's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

DHMP reported implementing CAPs for providers that score below a 95 percent and have a sufficient number of records to assess general documentation practices. The CAPs may include requirements such as root cause analyses, retraining staff, systems enhancements, and/or provider re-audits. DHMP reported offering providers education and training on quality documentation in collaboration with its Quality Department, Practice Support Team, and provider network managers.

Based on DHMP's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

Encounter Data Validation—DHMP 412 Over-Read

Table 4-131 presents DHMP's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 4-131—FY 2022–2023 Self-Reported EDV Results by Data Element and Service Category for DHMP

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	96.1%	98.1%	94.2%	100.0%
Through Date	98.1%	NA	NA	NA
Diagnosis Code	89.3%	94.2%	77.7%	85.4%
Surgical Procedure Code	98.1%	NA	NA	NA
Procedure Code	NA	90.3%	85.4%	84.5%
Procedure Code Modifier	NA	96.1%	93.2%	98.1%
Discharge Status	93.2%	NA	NA	NA
Units	NA	96.1%	99.0%	100.0%

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

Table 4-132 presents DHMP's FY 2022–2023 EDV over-read case-level and element-level accuracy rates by service category.

Table 4-132—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	99.2%
Outpatient	20	85.0%	100	97.0%
Professional	20	85.0%	100	96.0%
FQHC	20	95.0%	100	99.0%
Total	80	90.0%	420	97.9%

DHMP: Strengths

Based on MCO 412 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- HSAG agreed with 97.9 percent of DHMP's internal validation results for the total number of individual data elements reviewed. This number is higher than the 96.7 percent agreement rate reported in FY 2021–2022.

- HSAG's over-read results suggest a high level of confidence that DHMP's independent validation findings accurately reflect the encounter data quality summarized in the self-reported service coding accuracy results.
- The self-reported service coding accuracy results showed that all five key data elements for the outpatient cases had accuracy rates greater than 90 percent.

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

HSAG found the following opportunities for improvement:

- The accuracy rate for the *Diagnosis Code* data element was only 77.7 percent among the professional encounters in the self-reported service coding accuracy report.
- The varying service coding accuracy rates show that the service coding accuracy is not consistent across the four service categories.

To address these opportunities for improvement, HSAG recommends DHMP:

- Consider internal data monitoring and provider training to improve medical record documentation.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended that DHMP consider internal data monitoring and provider training to improve medical record documentation.

Assessment of DHMP's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

DHMP reported implementing the following approaches to address encounter data recommendations:

- To increase providers' engagement in their education and knowledge of the correct billing practices, DHMP reprocessed claims with errors to encourage providers to reach out to DHMP staff to understand the error and review/correct their process for coding the claims.
- UC Health Medical Group was selected as the QUIP pilot partner for the outpatient encounters. DHMP reported that the outreach and collaboration with this group provided insights to the complex process for the UC Health system to code claims.
- DHMP continues to experience an increase in the error rate due to providers not submitting the medical records for review against the claim. The DHMP provider team assigned a member to outreach and engage the associated providers to provide education. During the intervention sampling months, all medical records requested from these organizations were received timely.

Based on DHMP's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve encounter data.

CAHPS Survey

DHMP: Adult CAHPS

Table 4-133 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2020–2021 through FY 2022–2023.

Table 4-133—Adult Medicaid Top-Box Scores for DHMP

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	58.0%	58.6%	58.9%
Rating of All Health Care	58.1%	52.8%	51.1%
Rating of Personal Doctor	77.7%	68.9%	68.2%
Rating of Specialist Seen Most Often	63.2%	70.6%	62.0%
Getting Needed Care	84.1%	71.7%	72.0% ↓
Getting Care Quickly	79.9%	71.3%	71.3% ↓
How Well Doctors Communicate	94.2%	92.1%	91.7%
Customer Service	91.5%	87.9%	88.9%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

DHMP: Strengths

The following measures' FY 2022–2023 scores for DHMP were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measures' FY 2022–2023 scores for DHMP were statistically significantly lower than the 2022 NCQA national averages:

- *Getting Needed Care* 🔑
- *Getting Care Quickly* ⏱️

To address these low CAHPS scores, HSAG recommends DHMP:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality, timeliness, and accessibility of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

DHMP: Child CAHPS

Table 4-134 shows the child Medicaid CAHPS results achieved by DHMP for FY 2020–2021 through FY 2022–2023.

Table 4-134—Child Medicaid Top-Box Scores for DHMP

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	68.4%	72.3%	73.1%
Rating of All Health Care	76.5% +	70.7%+	72.4%+
Rating of Personal Doctor	80.6%	82.3%	84.6% ↑
Rating of Specialist Seen Most Often	80.8% +	87.5%+	65.0%+
Getting Needed Care	84.8% +	80.2%+	71.4%+ ↓
Getting Care Quickly	89.0% +	82.1%+	78.1%+

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
How Well Doctors Communicate	96.3% +	93.7%+	94.0%+
Customer Service	91.3% +	89.6%+	88.9%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

DHMP: Strengths

The following measure's FY 2022–2023 score for DHMP was statistically significantly higher than the 2022 NCQA national average:

- *Rating of Personal Doctor*

The following measures' FY 2022–2023 scores for DHMP were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measure's FY 2022–2023 score for DHMP was statistically significantly lower than the 2022 NCQA national average:

- *Getting Needed Care*

To address these low CAHPS scores, HSAG recommends DHMP:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality, timeliness, and accessibility of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for parents/caretakers of child members.
- Direct parents/caretakers to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, DHMP reported engaging in the following QI initiatives:

- Continued to improve communication with clinics about health plan quality improvement 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.
- Shared information with the newly formed DHHA Access to Care Committee regarding members who were unable to schedule a timely visit with their PCP or specialty care provider. This committee is charged with improving access to care at DHHA and utilizes these data to make necessary changes to the availability of appointments at DHHA.
- Implemented focused member outreach and CM to facilitate care transitions when acuity of need was identified.
- Increased types of appointments (SBHCs, eye exams, mammograms) that can be scheduled using MyChart.
- Revamped the DHMP member resources section of the DHMP website. The new version makes it easier for members to find important information about plan benefits, preventive care, access to care, care and follow-up of important chronic conditions, and help with basic needs (food, utilities, etc.).
- Converted all CAHPS production activities into Smartsheet for a more streamlined and organized process between the CAHPS vendor and DHMP internal staff.

Assessment of DHMP's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that DHMP addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with DHMP.

Quality Improvement Plan—411 QUIP

Table 4-135 presents DHMP's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-135—Summary of DHMP 411 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Primary Diagnosis Code	85%	100%	100%	100%
Psychotherapy Services	Procedure Code	76%	100%	100%	100%
	Diagnosis Code	89.1%	100%	100%	100%
	Place of Service	73%	0%	0%	0%
	Service Category Modifier	76%	100%	100%	100%
	Duration	87%	100%	100%	100%
	Staff Requirement	86%	100%	100%	100%

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

DHMP: Strengths

Based on 411 QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP reached 100 percent accuracy for six out of seven data elements in the QUIP. Most notably, two psychotherapy services data elements (*Procedure Code* and *Service Category Modifier*) improved from 76 percent to 100 percent in month one and maintained 100 percent accuracy throughout the intervention period.
- Key interventions for the QUIP included issuing CAPs to the pilot partners, which directed additional training and education to address low accuracy scores.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the 411 QUIP

HSAG found the following opportunities for improvement:

- One data element (*Place of Service*) for the psychotherapy services claim type had 0 percent accuracy for months one, two, and three; therefore, the *Place of Service* data element ultimately did not improve

above the 90 percent accuracy threshold. DHMP reported that this was due to not receiving any medical records from the pilot partners.

To address these opportunities for improvement, HSAG recommends DHMP:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 411 QUIP Recommendations

FY 2021–2022 411 QUIP Recommendations

FY 2022–2023 was the first year for DHMP 411 QUIP activities; therefore, follow-up on the prior year's DHMP 411 QUIP recommendations is not applicable.

Assessment of DHMP's Approach to Addressing FY 2021–2022 411 QUIP Recommendations

This section is not applicable to DHMP.

Quality Improvement Plan—412 QUIP

Table 4-136 presents DHMP's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-136—Summary of DHMP 412 QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Outpatient Services	Diagnosis Code	86%	100%	80%	80%
	Procedure Code	89%	100%	80%	80%
Professional Services	Diagnosis Code	77%	73%	60%	93%
	Procedure Code	78%	93%	100%	86%
FQHC	Diagnosis Code	88%	86%	80%	80%
	Procedure Code	81%	80%	73%	66%

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

DHMP: Strengths

Based on 412 QUIP activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP's interventions resulted in improvement in two out of the six data elements for the QUIP.
- DHMP addressed low outcomes by providing education to the provider to correct identified claim errors. DHMP reinforced correct billing practices by issuing overpayment requests to the provider.
- DHMP reported diagnosis code accuracy improved in month three, and the result for the *Diagnosis Code* data element increased overall from 77 percent to 93 percent.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the 412 QUIP

HSAG found the following opportunities for improvement:

- The overall results for the outpatient services claim type were impacted by challenges related to DHMP's pilot partner not correctly identifying and submitting the requested medical records.

To address these opportunities for improvement, HSAG recommends DHMP:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 412 QUIP Recommendations

FY 2021–2022 412 QUIP Recommendations

HSAG recommended that DHMP continue to educate providers about correct billing practices by reprocessing claims with errors and encouraging providers to reach out to staff members to understand the error and review/correct the process for coding claims.

Assessment of DHMP's Approach to Addressing FY 2021–2022 412 QUIP Recommendations

DHMP reported educating providers about correct billing practices and encouraging communication between DHMP and providers to correct and understand the process for coding claims. DHMP assigned a staff member to outreach and engage the providers to provide education due to the increase in providers not submitting medical records against the claim. DHMP responded to each component of HSAG's FY 2021–2022 QUIP recommendations. HSAG recognizes that education and consistent communication is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-137 displays the MHP Audit compliance scores for DHMP for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-137—FY 2022–2023 MHP Audit Score for DHMP

MCO	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD and M/S Services				
DHMP	97%	Inpatient	98%	97%~
		Outpatient	96%	

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

DHMP: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP showed consistent performance with a 97 percent total score for both FY 2021–2022 and FY 2022–2023.
- DHMP delegated UM activities for BH services to COA, and followed policies and procedures regarding adequate monitoring and oversight of delegated activities.
- COA used InterQual UR criteria for all MH determinations and ASAM LOC criteria for all SUD determinations.
- DHMP and COA required their UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- In all 10 inpatient and 10 outpatient cases reviewed, all cases demonstrated that COA followed DHMP's 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.
- COA made the denial determinations within the required time frame, and providers were notified of the denial determination through telephone or secure email and received a copy of the NABD for all records reviewed.
- In all cases reviewed, the denial determination was made by a qualified clinician, and the applicable cases contained evidence that the peer-to-peer review was offered to the requesting provider.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in COA's UM system. Additionally, all NABDs included the required content such as

the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from DHMP when filing, access to pertinent records, and the reason for the denial.

- COA and DHMP reported a new NABD template that was developed to explain to DHMP members how COA coordinates BH services on behalf of DHMP.
- During the MHP interview, DHMP staff members explained the open communication lines and regular standing meetings between DHMP and COA to ensure that staff members are aware of UM changes or updates and to provide opportunities to discuss and collaborate between the two entities.

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

HSAG found the following opportunities for improvement:

- COA did not always send the member an NABD within the required time frame.
- While the NABDs included the required content, such as the member's appeal rights and the reason for the denial, one inpatient SUD NABD did not include the required ASAM dimensions and how they were considered when determining medical necessity within the NABD.
- The NABDs reviewed did not always score at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
- COA did not use the new NABD template consistently after implementation.

To address these opportunities for improvement, HSAG recommends DHMP:

- Enhance monitoring procedures to ensure that the member is sent the NABD within the required time frame.
- Periodically train staff members and conduct monthly record audits to ensure NABDs are at an easy-to-understand reading grade level and include the required language, such as the ASAM dimensions within inpatient and residential SUD NABDs. Additionally, ensure staff members who are assigned to DHMP authorizations use the correct revised template regarding DHMP's delegation to COA.
- As a best practice, other than the SUD NABDs, which ordinarily included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended 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 or if the letter should explain the delegation to COA to avoid confusion for the member.

Assessment of DHMP's Approach to Addressing FY 2021–2022 MHP Recommendations

DHMP reported addressing HSAG's recommendations by:

- Collaborating closely with COA to ensure parity. This includes being a standing item for the biannual DHMP/COA UM team meeting, which includes a discussion about how in- and out-of-network terminology is utilized by each organization and the impact it may have on parity.
- Monitoring denial cases to ensure that notifications are sent to members in a timely manner.

Additionally, DHMP reported an additional update to address a statewide recommendation such as conducting staff training and internal audits to confirm complete documentation of the peer-to-peer review process.

DHMP still has the opportunity to address HSAG's recommendations of including the specific name of the criteria used to make the denial determination within the NABD. DHMP reported updates will most likely help DHMP demonstrate continuous improvement and/or consistency to overall UM processes. DHMP should continue to address the recommendations made by HSAG to achieve MHP compliance.

QOC Concern Audit

The QOC Concern Audit was not conducted with DHMP in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, DHMP investigated any QOC concern that was related to a member's PH and subcontracted with COA to investigate any QOC concern related to a member's BH services. HSAG recommended:

- COA continue ongoing staff training on the Colorado-specific QOC grievance 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, HSAG recommended COA implement a process for QOC concern 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 QOC concerns 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 concerns, 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 concerns to COA.

Assessment of DHMP's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

DHMP reported addressing HSAG's recommendations by:

- Continuing to anticipate new guidance for contract and regulatory changes and initiating activities in support of the anticipated changes.
- Capturing grievances reported via oral or written submission.

- Creating a new drop-down field in its software system to accurately capture grievances for Medicaid members to track the volume of occurrences.
- Completing training for Health Plan Services (HPS), grievance and appeals (G&A), and UM staff members.
- Creating a new grievance and appeal log.
- Updating DHMP's QOC policy.
- Collaborating with HPS, G&A, the compliance department, and the medical director regarding new changes to QOC grievances.

HSAG anticipates DHMP's response to the recommendations is likely to improve overall processes and compliance with contractual requirements. DHMP should continue to address the recommendations made by HSAG and continue to make updates based on guidance from the Department for upcoming contractual changes and reporting requirements. Additionally, DHMP should work with COA to ensure consistency with QOC concern/grievance investigation processes.

EPSDT Audit

Table 4-138 displays the findings derived from the following audit activities conducted in FY 2022–2023: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2021–2022.

Table 4-138—FY 2022–2023 EPSDT Audit Findings for DHMP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	100%	100%
Non-Utilizer Record Review	100%	33%	63%
Post-Denial Record Review	83%	67%	75%

DHMP: Strengths

Based on EPSDT Audit activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP and its delegate, COA, applied the EPSDT definition of "medical necessity" in part or all of the denial cases reviewed. DHMP applied InterQual guidelines for all records reviewed, including those that were denied due to a noncovered diagnosis/benefit.
- DHMP providers received information regarding EPSDT in the provider manual at the time of onboarding and through provider newsletters at least every six months. Informational flyers were distributed to newly enrolled Medicaid members and/or members identified as needing CM and

included topics such as lead exposure management, carbon monoxide, the Bright Futures Periodicity Schedule, and more specific EPSDT provider newsletters and flyers.

- In addition to the Department's initial attempts to obtain a HRA, DHMP contracted with SPH Analytics to perform initial health needs assessments, both in writing and via telephone.
- DHMP attempted to identify members with SHCN through claims or encounter data, hospital discharge and admission data, pharmacy data, and UM data.
- DHMP's Q4 FY 2021–2022 EPSDT Outreach Report indicated outreach was attempted and marked as 100 percent successful across all methods: email, text, phone, and other, which included "in person reminder" for those seeing a specialist who still need a regular visit.
- Most non-utilizer sample cases reviewed included evidence that the *Healthy Heroes* mailer (a postcard) was sent within the month of the member's birthday during the review period. The mailer prompted the member to make an appointment for a wellness exam.
- The denial cases reviewed demonstrated that DHMP UM staff members considered the individual member's needs, purpose of the service, whether the requested service was appropriate, whether any treatment or other LOCs had been provided, and availability of family support within most cases reviewed.
- DHMP's UM policies and NABD template included the Department template language regarding EPSDT. Furthermore, many of the denial sample cases reviewed included member-specific information within the NABD.
- Documentation within many denial sample cases demonstrated that CM support occurred, and the cases included warm handoffs and/or follow-ups by CM.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- DHMP staff members reported that the MCE does not track returned mail to determine if the outreach was successful.
- Member newsletters contained information about EPSDT, and both the newsletters and the "birthday" cards encouraged members to schedule appointments; however, neither the "birthday" cards nor the newsletters were targeted to a member's situation related to not using particular EPSDT services.
- None of the NABDs reviewed offered assistance with scheduling appointments or transportation.

- The UR Determinations EPSDT policy stated that DHMP "will direct the provider to the State Department" but did not include details about how DHMP would support the provider or work with the State directly to request the services. The policy also stated that DHMP will make two attempts to notify the requesting provider about a denial decision, but it did not describe how DHMP helps ensure the provider understands how to request the services the MCE does not cover. In the five applicable cases, only two cases provided evidence of working with the requesting provider regarding a service that the MCE does not cover.

To address these opportunities for improvement, HSAG recommends DHMP:

- Consider assessing the amount of returned mail DHMP receives if mailing is the sole outreach method.
- Target non-utilizer outreach to help members understand which services are being recommended.
- Consider adding the EPSDT flyer to applicable member letters, so members are aware of the program and eligibility.
- Further detail in its procedures how DHMP will participate in warm transfers to help members and family members engage with other agencies, as appropriate.

During the FY 2022–2023 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- DHMP's sample records showed that none of the members who received outreach at the time of enrollment returned the HRA form, and HSAG could not find evidence of implementation to demonstrate DHMP followed up to offer services or support for SHCN.
- DHMP reported outreach efforts completed through the MyChart portal; however, there were no MyChart outreaches reported to HSAG as part of this audit. HSAG questions whether non-utilizer members would have access to or would be checking notifications within the DHMP member portal to receive such outreach.
- DHMP only distributed postcards during the month of the member's birthday for its annual outreach strategy, and no further outreach was conducted within the non-utilizer sample reviewed.
- DHMP has the opportunity to improve its NABD template to include more member-specific information.

Although these findings did not lead to recommendations, HSAG informed DHMP of these findings within the report. DHMP should work on addressing these findings to improve processes, procedures, and trainings.

Follow-Up on FY 2021–2022 EPSDT Recommendations

FY 2022–2023 was the first year for EPSDT Audit activities; therefore, follow-up on the prior year's EPSDT recommendations is not applicable.

Substance Use Disorder Utilization Management Over-Read

Table 4-139 presents the number of cases in the sample that HSAG reviewed for DHMP and the percentage of cases in which HSAG reviewers agreed with DHMP's denial determination.

Table 4-139—DHMP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
DHMP	16	16	100%

DHMP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- HSAG reviewers agreed with all DHMP denial decisions.
- In all sample cases reviewed, DHMP notified the provider of the denial determination within the required time frame.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- Of the 16 cases reviewed, documentation showed that 15 notices were sent to the members and, of those notices, only 12 were timely.

To address these opportunities for improvement, HSAG recommends DHMP:

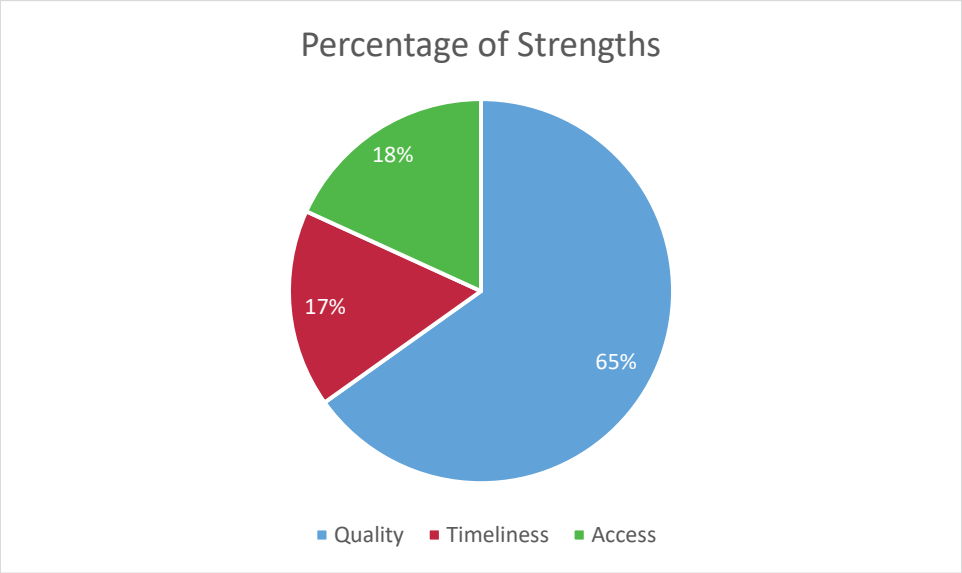
- Update policies, procedures, and processes to ensure that members receive a NABD and within the required time frame.

Follow-Up on FY 2021–2022 SUD UM Over-Read Recommendations

FY 2022–2023 was the first year for SUD UM Over-Read Audit activities; therefore, follow-up on the prior year's SUD UM Over-Read Audit recommendations is not applicable.

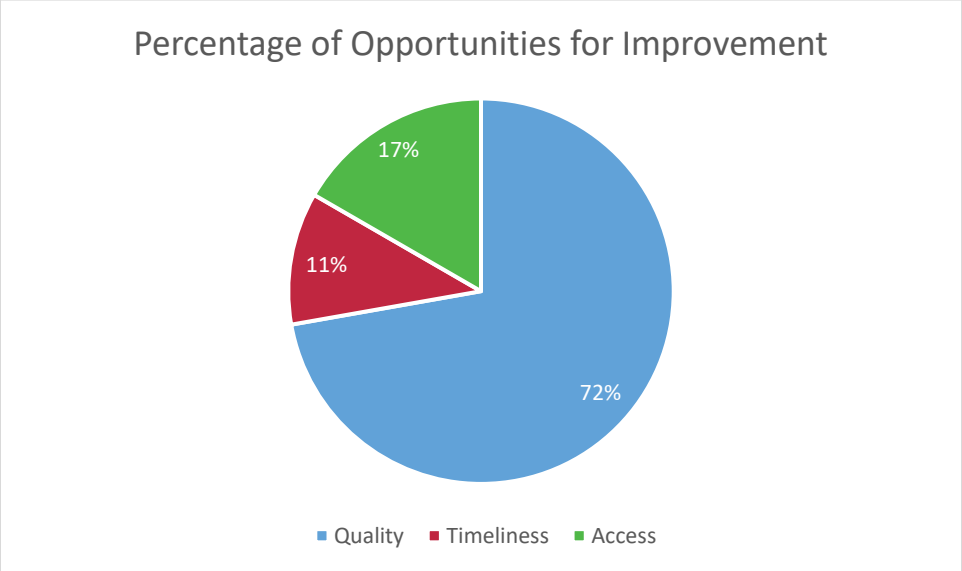
Rocky Mountain Health Plans Medicaid Prime

Figure 4-17—Percentage of Strengths by Care Domain for RMHP Prime*



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

Figure 4-18—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, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, 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 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, RMHP Prime established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021 and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-140 and Table 4-141 summarize RMHP Prime's PIP activities that were completed and validated in FY 2020–2021. Table 4-140 provides the SMART Aim statements that RMHP Prime defined for the two PIP outcome measures in Module 1.

Table 4-140—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 4-141 summarizes the preliminary key drivers and potential interventions RMHP Prime identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-141—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.

Table 4-142 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-142—Intervention Testing Plan 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	• 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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
result (G8510) and positive result (G8431)			• 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 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

FY 2022–2023 PIP Activities

In FY 2022–2023, RMHP Prime continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed the initial Module 4 submission form, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

HSAG analyzed RMHP Prime's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated RMHP Prime's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for RMHP Prime's PIP are presented in Table 4-143. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-143—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings for RMHP Medicaid Prime members ages 12 and older attributed to MFHC or SMFM.	0.55%	20.00%	5.77%	*Yes*
Follow-Up After a Positive Depression Screen				
The percentage of RMHP Prime members ages 12 and older attributed to MFHC or SMFM who screen positive for depression that are successfully connected to appropriate BH services within 30 days.	37.50%	46.89%	81.82%	*No*

To guide the project, RMHP Prime established goals of increasing the percentage of members 12 years of age and older, attributed to SMFM or MFHC, who received a depression screening from 0.55 percent to 20.00 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 37.50 percent to 46.89 percent, through the SMART Aim end date of June 30, 2022. RMHP Prime's reported SMART Aim measure results demonstrated a statistically significant improvement of 5.22 percentage points from baseline to the highest rate achieved, 5.77 percent; however, the SMART Aim goal was not achieved. For the *Follow-Up After a Positive Depression Screen* measure, the

highest rate achieved, 81.82 percent, exceeded the goal and represented an improvement of 44.32 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, RMHP Prime completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-144summarizes RMHP Prime's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-144—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
MFHC Intervention 1: Develop, implement, and train MAs and providers on a new workflow to score, document, and accurately code depression screens with a negative result (G8510) and positive result (G8431).	Significant *programmatic* improvement for *Depression Screening*	Adopted
SMFM Intervention 1: Integrate G-codes into workflow to ensure proper measurement capture of G8431 and G8450. Review and revise SMFM workflow for using G-codes.	*None*	Abandoned
MFHC Intervention 2: Develop and deploy a registry for patients who score positive on the PHQ-9 to guide BHAs to connect to patients for BH follow-up when appropriate.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
SMFM Intervention 2: Create a standardized depression screening billing and CPT coding workflow for the partner provider.	*None*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *Moderate Confidence*.

RMHP Prime: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP Prime:

- RMHP Prime developed and carried out a methodologically sound improvement project.
- RMHP Prime accurately reported intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure and achievement of the SMART Aim goal for the *Follow-Up After a Positive Depression Screen* measure.
- RMHP Prime's intervention testing results demonstrated programmatically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions.

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

Based on PIP validation activities conducted in FY 2022–2023, HSAG identified an opportunity for improvement in accurately reporting PIP findings and results. The health plan provided an accurate narrative summary of key findings for the *Depression Screening* measure but documented an inaccurate summary of key findings for the *Follow-Up After a Positive Depression Screen* measure. To address this opportunity for improvement, HSAG recommends the following for future improvement activities:

- RMHP Prime should ensure that all documented interpretation of results, key findings, and conclusions are accurate and supported by reported data.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of RMHP Prime's PIP, HSAG recommended:

- 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.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 PIP Recommendations

RMHP Prime successfully addressed HSAG's FY 2021–2022 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 in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of a consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

HEDIS/Core Set Measure Rates and Validation

RMHP Prime: Information Systems Standards Review

According to the HEDIS MY 2022 FAR, RMHP Prime was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted RMHP Prime's performance measure reporting.

RMHP Prime: Performance Measure Results

Table 4-145 shows the performance measure results for RMHP Prime for MY 2020 through MY 2022, along with the percentile ranking for each MY 2022 rate, if available. Rates for MY 2022 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2022 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Table 4-145—Performance Measure Results for RMHP Prime

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
Ages 52 to 64 Years[H]	—	40.89%	44.34%^	WTSA

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Ages 65 to 74 Years[H]	—	39.03%	41.15%	BTSA
Cervical Cancer Screening				
Cervical Cancer Screening[H]	40.27%	42.34%	42.38%	<10th
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	46.43%	62.99%	51.35%	25th–49th
Ages 12 to 17 Years[H]	43.71%	56.63%	59.12%	75th–89th
Ages 18 to 21 Years[H]	13.15%	13.53%	15.95%	<10th
Total[H]	19.40%	23.86%	28.73%	<10th
Childhood Immunization Status				
DTaP[H]	NA	NA	NA	—
IPV[H]	NA	NA	NA	—
MMR[H]	NA	NA	NA	—
HiB[H]	NA	NA	NA	—
Hepatitis B[H]	NA	NA	NA	—
VZV[H]	NA	NA	NA	—
Hepatitis A[H]	NA	NA	NA	—
Pneumococcal Conjugate[H]	NA	NA	NA	—
Rotavirus[H]	NA	NA	NA	—
Influenza[H]	NA	NA	NA	—
Combination 3[H]	NA	NA	NA	—
Combination 7[H]	NA	NA	NA	—
Combination 10[H]	NA	NA	NA	—
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	45.08%	41.67%	39.34%	10th–24th
Ages 21 to 24 Years[H]	45.02%	45.10%	49.60%	<10th
Colorectal Cancer Screening				
Ages 46 to 49 Years[H]	—	—	16.69%	BTSA
Ages 50 to 64 Years[H]	—	—	36.63%	BTSA
Ages 65 Years and Older[H]	—	—	36.43%	BTSA
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	NA	NA	—
2 Years[SA]	—	NA	NA	—
3 Years[SA]	—	NA	NA	—
Total[SA]	—	NA	NA	—
Immunizations for Adolescents				
Meningococcal[H]	NA	64.71%	80.00%^	25th–49th
Tdap[H]	NA	79.41%	83.33%^	25th–49th
HPV[H]	NA	11.76%	26.67%	<10th

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Combination 1[H]	NA	64.71%	80.00%^	50th–74th
Combination 2[H]	NA	8.82%	26.67%	10th–24th
Lead Screening in Children				
Lead Screening in Children[H]	—	—	NA	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	5.26%	10.61%	20.65%^	<10th
BMI Percentile—Ages 12 to 17 Years[H]	6.35%	13.82%	25.17%^	<10th
BMI Percentile—Total[H]	5.83%	12.32%	23.40%^	<10th
Counseling for Nutrition—Ages 3 to 11 Years[H]	22.81%	22.73%	30.43%	<10th
Counseling for Nutrition—Ages 12 to 17 Years[H]	18.25%	21.05%	23.08%	<10th
Counseling for Nutrition—Total[H]	20.42%	21.83%	25.96%	<10th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	0.00%	3.79%	13.04%^	<10th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	0.00%	1.97%	13.29%^	<10th
Counseling for Physical Activity—Total[H]	0.00%	2.82%	13.19%^	<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	NA	NA	—
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	NA	NA	NA	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	33.58%	30.09%	BTSA
MMEC—Ages 21 to 44 Years[SA]	—	20.17%	19.57%	BTSA
LARC—Ages 15 to 20 Years[SA]	—	6.51%	6.94%	BTSA
LARC—Ages 21 to 44 Years[SA]	—	4.87%	4.27%	WTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	0.00%	NA	—
MMEC—3 Days—Ages 21 to 44 Years[SA]	—	5.77%	6.70%	WTSA
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	34.78%	NA	—
MMEC—90 Days—Ages 21 to 44 Years[SA]	—	40.74%	42.16%	WTSA
LARC—3 Days—Ages 15 to 20 Years[SA]	—	0.00%	NA	—
LARC—3 Days—Ages 21 to 44 Years[SA]	—	0.00%	0.49%	WTSA
LARC—90 Days—Ages 15 to 20 Years[SA]	—	19.57%	NA	—
LARC—90 Days—Ages 21 to 44 Years[SA]	—	16.56%	17.16%	WTSA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	56.65%	56.53%	49.83%	<10th
Postpartum Care[H]	32.89%	36.95%	36.32%	<10th

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	NA	NA	—
Ages 12 to 18 Years[H]	—	NA	NA	—
Total (Ages 5 to 18 Years)[H]	—	NA	NA	—
Ages 19 to 50 Years[H]	—	56.71%	57.91%	25th–49th
Ages 51 to 64 Years[H]	—	58.89%	62.32%	50th–74th
Total (Ages 19 to 64 Years)[H]	—	57.22%	59.06%	BTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	NA	—	NA	—
Ages 18 to 64 Years[H]	47.24%	—	48.05%	50th–74th
Ages 65 Years and Older[H]	NA	—	NA	—
Concurrent Use of Opioids and Benzodiazepines				
Ages 18 to 64 Years[,SA]*	—	14.93%	**10.26%^^**	WTSA
Ages 65 Years and Older[,SA]*	—	19.29%	NA	—
Controlling High Blood Pressure				
Ages 18 to 64 Years[H]	—	25.22%	22.00%	WTSA
Ages 65 to 85 Years[H]	—	25.37%	23.06%	WTSA
HbA1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Ages 18 to 64 Years[H]	—	—	32.65%	WTSA
HbA1c Control (<8.0%)—Ages 65 to 75 Years[H]	—	—	40.00%	WTSA
Poor HbA1c Control (>9.0%)—Ages 18 to 64 Years[*,H]*	—	69.74%	61.39%	WTSA
Poor HbA1c Control (>9.0%)—Ages 65 to 75 Years[*,H]*	—	66.67%	52.31%^	WTSA
HIV Viral Load Suppression				
Ages 18 to 64 Years[SA]	—	0.00%	0.00%	—
Ages 65 Years and Older[SA]	—	NA	NA	—
Use of Opioids at High Dosage in Persons Without Cancer				
Ages 18 to 64 Years[,SA]*	—	4.11%	3.36%	BTSA
Ages 65 Years and Older[,SA]*	—	2.48%	NA	—
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	—	59.11%	60.57%	25th–49th
Antidepressant Medication Management				
Effective Acute Phase Treatment—Ages 18 to 64 Years[H]	—	57.44%	62.96%^	WTSA
Effective Acute Phase Treatment—Ages 65 Years and Older[H]	—	NA	78.79%	BTSA
Effective Continuation Phase Treatment—Ages 18 to 64 Years[H]	—	39.67%	43.84%	WTSA

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Effective Continuation Phase Treatment—Ages 65 Years and Older[H]	—	NA	42.42%	WTSA
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)				
Ages 18 to 64 Years[*,H]*	—	58.37%	56.28%	WTSA
Ages 65 to 75 Years[*,H]*	—	NA	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%	79.22%	25th–49th
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	38.74%	31.51%	25th–49th
7-Day Follow-Up—65 Years and Older[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	54.05%	46.12%	25th–49th
30-Day Follow-Up—65 Years and Older[H]	—	NA	NA	—
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	21.69%	—
7-Day Follow-Up—Ages 65 Years and Older[H]	—	—	NA	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	—	36.11%	—
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	NA	—
7-Day Follow-Up—Ages 18 to 64 Years[H]	—	38.84%	33.98%	50th–74th
7-Day Follow-Up—Ages 65 Years and Older[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
30-Day Follow-Up—Ages 18 to 64 Years[H]	—	56.51%	52.65%	25th–49th
30-Day Follow-Up—Ages 65 Years and Older[H]	—	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	NA	NA	NA	—
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Alcohol—Ages 18 to 64 Years[H]	—	—	35.16%	—
Initiation of SUD Treatment—Alcohol—Ages 65 Years and Older[H]	—	—	36.36%	—
Initiation of SUD Treatment—Opioid—Ages 18 to 64 Years[H]	—	—	37.83%	—
Initiation of SUD Treatment—Opioid—Ages 65 Year and Older[H]	—	—	NA	—

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Initiation of SUD Treatment—Other Drug—Ages 18 to 64 Years[H]	—	—	29.65%	—
Initiation of SUD Treatment—Other Drug—Ages 65 Years and Older[H]	—	—	NA	—
Initiation of SUD Treatment—Total—Ages 18 to 64 Years[H]	—	—	33.01%	—
Initiation of SUD Treatment—Total—Ages 65 Years and Older[H]	—	—	36.49%	—
Engagement of SUD Treatment—Alcohol—Ages 18 to 64 Years[H]	—	—	12.84%	—
Engagement of SUD Treatment—Alcohol—Ages 65 Years and Older[H]	—	—	3.03%	—
Engagement of SUD Treatment—Opioid—Ages 18 to 64 Years[H]	—	—	23.22%	—
Engagement of SUD Treatment—Opioid—Ages 65 Years and Older[H]	—	—	NA	—
Engagement of SUD Treatment—Other Drug—Ages 18 to 64 Years[H]	—	—	12.15%	—
Engagement of SUD Treatment—Other Drug—Ages 65 Years and Older	—	—	NA	—
Engagement of SUD Treatment—Total—Ages 18 to 64 Years[H]	—	—	13.65%	—
Engagement of SUD Treatment—Total—Ages 65 Years and Older[H]	—	—	1.35%	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	NA	46.88%	NA	—
Blood Glucose Testing—Total[H]	62.50%	47.37%	NA	—
Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	NA	40.63%	NA	—
Cholesterol Testing—Total[H]	34.38%	36.84%	NA	—
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	NA	37.50%	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	34.38%	34.21%	NA	—
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[SA]	—	7.69%	8.23%	WTSA
Ages 18 to 64 Years[SA]	—	7.28%	7.69%	WTSA
Ages 65 Years and Older[SA]	—	2.37%	2.89%	WTSA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	NA	NA	—
Total[H]	—	NA	NA	—
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	—	52.74%	63.56%^	BTSA
Rate 2: Buprenorphine[SA]	—	31.66%	36.44%^	WTSA
Rate 3: Oral Naltrexone[SA]	—	4.13%	4.10%	BTSA

Performance Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Percentile Ranking
Rate 4: Long-Acting, Injectable Naltrexone[SA]	—	0.72%	0.93%	WTSA
Rate 5: Methadone[SA]	—	20.54%	29.17%^	BTSA
Use of Services				
Ambulatory Care: Emergency Department Visits				
*<1 Year**[,SA]	—	32.76	NA	—
*Ages 1 to 9 Years**[,SA]	—	35.46	420.68	—
*Ages 10 to 19 Years**[,SA]	—	NA	520.84	—
*Total (Ages 0 to 19 Years)**[,H]	—	34.94	502.90	—
PQI 01: Diabetes Short-Term Complications Admission Rate				
*Ages 18 to 64 Years**[,SA]	—	27.29	11.13	—
*Ages 65 Years and Older**[,SA]	—	18.41	9.51	—
PQI 05: COPD or Asthma in Older Adults Admission Rate				
*Ages 40 to 64 Years**[,SA]	—	258.84	9.03	—
*Ages 65 Years and Older**[,SA]	—	1210.72	25.36	—
PQI 08: Heart Failure Admission Rate				
*Ages 18 to 64 Years**[,SA]	—	76.05	5.20	—
*Ages 65 Years and Older**[,SA]	—	1033.38	28.53	—
PQI 15: Asthma in Younger Adults Admission Rate				
*Ages 18 to 39 Years**[,SA]	—	6.65	2.37	—
Plan All-Cause Readmissions				
Observed Readmissions[H]	9.34%	7.92%	7.96%	—
Expected Readmissions[H]	—	9.83%	9.88%	—
*O/E Ratio**[,H]	0.93	0.81	0.8054	—
Outlier Rate[H]	—	—	33.91	—

**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.
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 there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2021 to MY 2022.

RMHP Prime: Strengths

The following HEDIS MY 2022 measure rates were determined to be high-performing rates for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2021, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2021):

- *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*
- *Immunizations for Adolescents—Combination 1*

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

The following HEDIS MY 2022 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 2021):

- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* and *Total*
- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Ages 21 to 24 Years*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

To address these low measure rates, HSAG recommends RMHP Prime:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the MCOs consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.

- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS/Core Set Measure Recommendations

FY 2021–2022 Performance Measure Recommendations

In FY 2021–2022, HSAG recommended RMHP Prime:

- As it relates to immunizations, remind parents to protect their children against serious 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.[4-3]
- 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.[4-4]
- 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 RMHP Prime's Approach to Addressing FY 2021–2022 HEDIS Recommendations

Based on the recommendations provided by HSAG, RMHP Prime reported implementing the following:

- A monthly dashboard was created to monitor, track, and trend performance measures.
- A BHIP expansion project kicked off in the fall of 2022 and launched in early 2023 by incentivizing PCMPs and IPN providers for being open to referrals and completing encounters in the time frame for the measures.
- For the Child and Adolescent Well-Care Visits and Well-Child Visits in the First 30 Months of Life measures, RMHP Prime reported implementing the following interventions:
  - Distributed annual wellness visit reminders along with education on the importance of annual wellness visits.
  - A workgroup that focused interventions for the pediatric population.

4-3 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: Nov 5, 2023.

4-4 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: Nov 5, 2023.

  - Created a social media campaign for annual wellness visits.
  - Conducted an annual audit to ensure data was captured correctly.
  - Submitted welcome guides to new members to provide education and recommendations regarding the importance of wellness visits.
  - Conducted welcome calls to new enrollees including warm transfer to primary care for appointment to provide education and promote annual well visits.
- For the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, RMHP Prime reported implementing the following interventions:
  - Distributed a postpartum care incentive and educational mailing brochure.
  - A workgroup that focused interventions for the maternity and women's care population.
  - Partnered with WellHop and SimpliFed to offer exclusive programs to its members. Through these programs, expectant moms could receive additional support during their pregnancies, postpartum, and with breastfeeding, pumping, formula feeding, or a combination.
- For the *Chlamydia Screening in Women* measure, RMHP Prime reported implementing the following interventions:
  - Distributed a women's health member email brochure that included a women's annual care checklist and recommended preventive screenings.
  - A workgroup that focused on interventions for the maternity and women's care population.
  - Posted educational materials to the provider portal.
  - Created a social media campaign for various screenings.
- For the *Cervical Cancer Screening* measure, RMHP Prime reported implementing the following interventions:
  - Distributed a women's health member email brochure that included a women's annual care checklist and recommended preventive screenings.
  - Created a workgroup that focused on interventions for the maternity and women's care population.
- For the *Asthma Medication Ratio* measure, RMHP Prime reported implementing the following interventions:
  - A workgroup that focused on interventions for the diabetic and chronic conditions population.
  - Posted educational materials to the provider portal.
- For the *Asthma in Younger Adults Admission Rate* measure, RMHP Prime reported implementing the following interventions:
  - A workgroup that focused on interventions for the diabetic and chronic conditions population.
  - Posted educational materials to the provider portal.

- For the *Childhood Immunization Status* measure, RMHP Prime implemented the following interventions:
  - Distributed new baby packets that included education regarding child safety, recommended immunizations by age 2, and promoted children's health and safety through routine well-child checks.
  - Distributed a two-year immunization mailing brochure incentive to members' parents/guardians at age 18 months; members' parents/guardians are eligible to receive a gift card upon completion and after showing proof of receiving all recommended immunizations by their child's second birthday.
  - Created a social media campaign for various immunizations.
- For the *Immunizations for Adolescents* measure, RMHP Prime implemented the following interventions:
  - Distributed monthly postcards for adolescents who missed an immunization between ages 16 to 18 years.
  - A workgroup that focused interventions for the pediatric population.
  - A social media campaign for various immunizations.
- For the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, RMHP Prime reported implementing the following interventions:
  - A workgroup that focused interventions for the pediatric population.
  - Distributed an educational flyer on follow-up care for children prescribed ADHD medication for providers.
- For the *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit* measures, RMHP Prime reported implementing the following interventions:
  - Integrated BH into many primary care practices to assist with transitions of care after hospitalizations and increase access.
  - Expanded the BH IPN to increase access to BH services and assist with transitions of care.
  - RMHP had a doctorate level integrated behavioral health advisor who assisted practices with BH workflows and implementation of best practices across RMHP's service area.

RMHP Prime reported strong member-, provider-, and community-facing interventions targeted to improve the quality of care and timely access to healthcare services. HSAG recommends evaluating the effectiveness of the interventions and the observed impact the interventions have on performance rates. This includes but is not limited to evaluating the percentage of members who received mailers and incentives that resulted in a rendered service. Lastly, based on the effectiveness of the intervention, determine the sustainability and spread plan to target other service types that may benefit from these types of interventions.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Prime Overall Evaluation

Table 4-146 presents the number of elements for each standard; the number of applicable elements within 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 2022–2023.

Table 4-146—Summary of RMHP Prime Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	33	2	0	0	94%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**86**	**86**	**81**	**5**	**0**	**0**	**94%***

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

Table 4-147 presents the compliance scores for record reviews conducted for RMHP Prime during FY 2022–2023.

Table 4-147—Summary of RMHP Prime Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Denials	100	70	67	3	30	96%
Grievances	60	52	52	0	8	100%
Appeals	60	58	54	4	0	93%
Totals	**220**	**180**	**173**	**7**	**38**	**96%***

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

RMHP Prime: Trended Performance for Compliance With Regulations

Table 4-148 presents, for all standards, the overall percentage of compliance score for RMHP Prime for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-148—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; 2022–2023)	**90%**	**94%**
Standard II—Adequate Capacity and Availability of Services (2016–2017; 2019–2020; 2022–2023)	**100%**	**92%**
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; 2022–2023)	**86%**	**94%**
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%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA****	**100%**

**Bold text indicates standards that were reviewed in FY 2022–2023.*
***NA indicates the first year of reviewing the standard.*

In FY 2022–2023, each of the four standards reviewed for RMHP Prime demonstrated consistent high-achieving and improved scores from the previous review cycle for two standards. Standard II—Adequate Capacity and Availability of Services declined by 8 percentage points but scored relatively high, demonstrating a general to strong understanding of most federal and State regulations.

RMHP Prime: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG found the following strengths for RMHP Prime:

- Documentation within the denial samples demonstrated extensive outreach to the provider when additional information or clarification was needed. Most files included at least two outreaches and some files included 10 or more documented efforts.
- Some NABDs included clear recommendations for the member to obtain the recommended alternative LOC and listed available providers in the area, including contact information.
- Staff members described ongoing efforts to continue expanding the RMHP Prime network, which included seeking Behavioral Health Administration funding whenever possible. Leadership noted a significant network gain with the provider, Integrated Insights Therapy, who serves the Delta, Gunnison, and Montrose regions. RMHP Prime provided support to this provider in order to scale and grow into new offices in western Montrose.
- RMHP Prime's cultural competency trainings, outreach, and initiatives described by staff members were extensive and specifically targeted to its membership. Staff members discussed a focus on SDOH and increasing assessments.
- RMHP Prime had a system in place to receive, log, and track a grievance request from the member at any time. RMHP Prime submitted a sample of 10 grievances that met 100 percent compliance for readability and timeliness of acknowledgment and resolution letters.
- Although the time frame to accept appeals from the member is 60 calendar days, RMHP Prime reported accepting appeals beyond the 60-calendar-day window, under certain circumstances. Staff members reported during the interview that if the member needed a service, RMHP Prime would assist the member in filing an appeal or start a new request for the alternative LOC recommended in the NABD.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to RMHP Prime's system with no restriction.

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

HSAG found the following opportunities for improvement:

- NABDs reviewed included acronyms or clinical terminology that could be explained in a more member-friendly manner.

- RMHP Prime identified a large-scale issue related to member claims denial notices. Staff members described that a glitch in the member letter file did not trigger the next step to notify the support services team, which processes and mails the member letters.
- Language related to authorization timelines in the *UM Program Description* did not clarify that the time frame starts at the time of the request.
- The *Standards for Practitioner Office Sites* policy incorrectly stated urgent and non-urgent care visit time frames and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits.
- The *UM Program Description* incorrectly stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider, which is inconsistent with updated federal requirements that no longer require the member to submit an appeal in writing.
- Four sample appeal resolution letters incorrectly required the member to request continuation of benefits in writing.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Conduct additional internal reviews and expand plain language explanations in a more member-friendly manner, whenever possible.
- Show evidence of a long-term update and ongoing monitoring to ensure all member letters are sent timely.
- Update language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.
- Update the *Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and include the exceptions related to when well-care visits should be scheduled prior to one month.
- Remove in the *UM Program Description* any references that require a member to submit appeal information in writing.
- Remove language that continuation of benefits must be submitted "in writing," as it is not a requirement by the federal regulations or State contract.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- 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.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, RMHP Prime updated its required member informational materials, updated policies to correctly detail the timeline to notify members of a terminated provider, and expanded its UM practices to include additional documentation about EPSDT medical necessity considerations. HSAG recognizes that the informational and policy updates are likely to result in long-term improvements, and the updated UM documentation protocol is likely to result in long-term improvements with ongoing monitoring.

Validation of Network Adequacy

RMHP Prime: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP Prime:

- RMHP Prime met all minimum network requirements for Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA), as well as Family Practitioners (MD, DO, NP, CNS, PA) in all contracted counties, across urbanicity. Additionally, RMHP Prime performed strongly in Pediatric Specialty provider categories, meeting all minimum network requirements for Pediatric Cardiology, Neurology, Ophthalmology, Orthopedics, Otolaryngology, Urology, Surgery, and Pulmonary Medicine in all contracted counties, across urbanicity. 
- RMHP Prime had match rates above 90 percent for all 10 PDV indicators. 

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 network requirements for Gynecology, OB/GYN (PA) in 88 percent of contracted counties or for Gynecology, OB/GYN (MD, DO, NP, CNS) in 44.4 percent of contracted counties, across county designation. 
- RMHP Prime did not meet the minimum network requirements for Acute Care Hospitals or General Endocrinology in 55.5 percent of total contracted counties, nor did RMHP Prime meet the minimum network requirements for Pediatric Endocrinology in 44.4 percent of total contracted counties across county designation. 
- Overall, 24.3 percent of RMHP Prime's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 71.5 percent were found at the sampled location. 

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Continue to conduct an in-depth review of provider categories for which RMHP Prime did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies, including a root cause analysis to identify the discrepancy in providers listed in the RMHP Prime data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that RMHP Prime seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, RMHP Prime reported taking the following actions:

- RMHP Prime maintained an open network policy for all providers within the contracted service area who meet RMHP Prime credentialing and quality standards. Given the rural and frontier nature of RMHP Prime's service area, RMHP Prime reports few new providers entering the region.
- RMHP Prime continued to expand a pilot project for e-consultants, which provides PCP access to specialist consultations with providers outside of members' immediate area, as well as outside of RMHP Prime's service area in select cases.

Based on the above response, RMHP Prime worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Encounter Data Validation—RMHP Prime 412 Over-Read

Table 4-149 presents RMHP Prime's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 4-149—FY 2022–2023 Self-Reported EDV Results by Data Element and Service Category for RMHP Prime

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	95.1%	89.3%	79.6%	99.0%
Through Date	96.1%	NA	NA	NA
Diagnosis Code	95.1%	83.5%	76.7%	94.2%
Surgical Procedure Code	95.1%	NA	NA	NA
Procedure Code	NA	87.4%	78.6%	95.1%
Procedure Code Modifier	NA	89.3%	78.6%	99.0%
Discharge Status	94.2%	NA	NA	NA
Units	NA	88.3%	78.6%	99.0%

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

Table 4-150 presents RMHP Prime's FY 2022–2023 EDV over-read case-level and element-level accuracy rates by service category.

Table 4-150—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	98.3%

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Outpatient	20	85.0%	100	97.0%
Professional	20	90.0%	100	98.0%
FQHC	20	95.0%	100	99.0%
Total	80	91.3%	420	98.1%

RMHP Prime: Strengths

Based on MCO 412 EDV activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP Prime:

- HSAG agreed with 98.1 percent of DHMP's internal validation results for the total number of individual data elements reviewed. This number is lower than the 98.3 percent agreement rate reported in FY 2021–2022.
- HSAG's over-read results suggest a high level of confidence that RMHP Prime's independent validation findings accurately reflect the encounter data quality summarized in the self-reported service coding accuracy results.
- The self-reported service coding accuracy results showed that all five key data elements for the inpatient and FQHC cases had accuracy rates greater than 90 percent.

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 noted in the encounter data quality report that it was unable to procure medical records for 16 out of the 412 sampled cases. While only two unprocured records were part of the over-read sample, if a high volume of medical records is not procured, the validity of the service coding accuracy report may be affected.
- The data elements reviewed for the professional cases were the least likely to be supported by medical record documentation; none of the five professional case data elements had a support rate greater than 80.0 percent.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Consider internal data monitoring and provider training to improve medical record documentation.

Follow-Up on FY 2021–2022 Encounter Data Recommendations

FY 2021–2022 Encounter Data Recommendations

In FY 2021–2022, HSAG recommended that RMHP Prime consider internal data monitoring and provider training to improve medical record documentation.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 Encounter Data Recommendations

RMHP Prime reported implementing the following approaches to address encounter data recommendations:

- The RMHP Prime Program Monitoring and Audit provided individualized results of the FY 2021–2022 Annual MCO Encounter Data Quality Review to impacted providers. RMHP Prime reviewers met with individual providers upon request to review failures and provide education on common billing, coding, and documentation errors and best practices.
- UnitedHealthcare (UHC) has various program integrity activities to identify and educate providers on billing, coding, and documentation standards.
- RMHP Prime determined a lack of response to medical record procurement requester to be a contributing factor to the FY 2021–2022 accuracy rates. RMHP Prime took steps to improve provider response rates for the FY 2022–2023 Annual MCO Encounter Data Quality Review.

Based on RMHP Prime's approach to addressing the FY 2021–2022 recommendations, HSAG believes these approaches have the potential to improve encounter data.

CAHPS Survey

RMHP: Adult CAHPS

Table 4-151 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2020–2021 through FY 2022–2023.

Table 4-151—Adult Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	55.1%	58.5%	70.5% ▲ ↑
Rating of All Health Care	53.9%	49.3%	55.3%
Rating of Personal Doctor	67.9%	61.2%	73.2% ▲
Rating of Specialist Seen Most Often	69.7% +	71.1%+	65.4%
Getting Needed Care	83.5%	83.6%	86.1%
Getting Care Quickly	80.2% +	80.2%	88.7% ▲ ↑

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
How Well Doctors Communicate	92.1%	87.4%	94.7% ▲
Customer Service	89.7% +	88.7%+	92.3%+

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

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

RMHP Prime: Strengths

The following measures' FY 2022–2023 scores for RMHP Prime were statistically significantly higher than the 2022 NCQA national averages:

- *Rating of Health Plan*
- *Getting Care Quickly*

The following measures' FY 2022–2023 scores for RMHP Prime were statistically significantly higher than the FY 2021–2022 scores:

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

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

The following measures' FY 2022–2023 scores for RMHP Prime were lower, although not statistically significantly, than the 2022 NCQA national averages:

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

The following measure's FY 2022–2023 score for RMHP Prime was lower, although not statistically significantly, than the FY 2021–2022 score:

- *Rating of Specialist Seen Most Often*

To address these low CAHPS scores, HSAG recommends RMHP Prime:

- Conduct root cause analyses or focus studies and obtain feedback on members' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality of the care and services they received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Consider any barriers to receiving timely care from specialists that may result in lower levels of experience.

RMHP: Child CAHPS

Table 4-152 shows the child Medicaid CAHPS results achieved by RMHP Prime for FY 2020–2021 through FY 2022–2023.

Table 4-152—Child Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	69.9%	68.7%	63.1% ↓
Rating of All Health Care	74.7%	63.2%	71.0%
Rating of Personal Doctor	75.0%	69.4%	69.8% ↓
Rating of Specialist Seen Most Often	73.0% +	79.6%+	76.3%+
Getting Needed Care	86.3%	85.4%	88.4%+
Getting Care Quickly	91.1%	87.5%	91.6%+ ↑
How Well Doctors Communicate	97.4%	96.8%	97.4%+ ↑
Customer Service	89.3% +	89.1%+	82.0%+

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 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

RMHP Prime: Strengths

The following measures' FY 2022–2023 scores for RMHP Prime were statistically significantly higher than the 2022 NCQA national averages:

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

The following measures' FY 2022–2023 scores for RMHP Prime were higher, although not statistically significantly, than the FY 2021–2022 scores:

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

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

The following measures' FY 2022–2023 scores for RMHP Prime were statistically significantly lower than the 2022 NCQA national averages:

- *Rating of Health Plan*
- *Rating of Personal Doctor*

To address these low CAHPS scores, HSAG recommends RMHP Prime:

- Conduct root cause analyses or focus studies and obtain feedback on parents'/caretakers' recent office visits through a follow-up call or email to determine what could be driving their lower perceptions of the quality and timeliness of the care and services their child received.
- Consider if there are disparities within their population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with parents/caretakers of child members.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To improve member perceptions related to FY 2021–2022 CAHPS results, RMHP Prime reported engaging in the following QI initiatives:

- Implemented a process within customer service to notify Provider Relations and the VBCRC when it is informed by members that a healthcare provider is not accepting new patients or is requiring applications for acceptance. Provider Relations follows up with the provider to investigate and address members' concerns. Additionally, this is tracked in the VBCRC to evaluate objectively if the practices are meeting the openness to Medicaid requirements based on their value-based contracts.
- During member welcome calls, customer service educates members on the importance of having a primary care relationship with a PCP. Customer Service asks members if they have a PCP and if they have an appointment coming up. If a member does not have a PCP, Customer Service offers to help the member find one and connect with the office to schedule an appointment.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, more in the last year. This included member mailers and emails, adding QR codes to existing mailers, and business cards for care coordinators and external stakeholders to distribute with CirrusMD for information.
- Included member experience topics in newsletter articles, learning collaborative events, and webinar series. Topics included leadership training, behavioral health skills training, and CM training.
- Provided cultural competency training to providers at health equity training, CM training, and behavioral health skills training.
- Expanded the eConsult program 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, empower the primary care practice, and increase education/clinical pathways within primary care.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that RMHP Prime addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with RMHP Prime.

Quality Improvement Plan

Table 4-153 presents RMHP Prime's data element accuracy from baseline through the three months post intervention for all claim types.

Table 4-153—Summary of RMHP Prime QUIP Outcomes

Claim Type	Data Element	Baseline	First Month	Second Month	Third Month*
Outpatient Services	Date of Service	76%	95%	100%	100%
	Diagnosis Code	75%	95%	100%	100%
	Procedure Code	76%	95%	100%	100%
	Procedure Code Modifier	75%	95%	100%	100%
	Units	74%	95%	100%	100%
Professional Services	Date of Service	59%	0%	0%	0%
	Diagnosis Code	55%	0%	0%	0%
	Procedure Code	55%	0%	0%	0%
	Procedure Code Modifier	57%	0%	0%	0%
	Units	56%	0%	0%	0%
FQHC	Date of Service	89%	100%	100%	100%
	Diagnosis Code	89%	100%	100%	100%
	Procedure Code	85%	95%	100%	100%
	Procedure Code Modifier	87%	100%	100%	100%
	Units	88%	100%	100%	100%

**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 2022–2023, HSAG found the following strengths for RMHP Prime:

- RMHP Prime's interventions resulted in improvement in 10 out of 15 data elements for the QUIP, of which all 10 exceeded the 90 percent accuracy threshold and achieved 100 percent accuracy by the end of the project.

- RMHP Prime addressed low outcomes by sending a summary of the results to the provider with the reviewer's detailed notes on how and why items were found to be inaccurate.
- RMHP Prime updated the Claim Encounter Educational Guide to be a more issue-focused guide, rather than general education.
- RMHP Prime sent all providers who failed to submit records for the MCO 412 EDV audit the Documentation Requirements education materials. RMHP Prime notified providers of possible retraction for noncompliance and unsupported billing, and reinforced education attempts with targeted retraction of payment for claims in certain circumstances. RMHP Prime implemented a CAP related to medical record collection processes. RMHP Prime's medical record collection rate reportedly increased by 10.7 percentage points from 85.7 percent to 96.4 percent.
- RMHP Prime reported an improvement in the outpatient services claim type accuracy rates for all five data elements, which continued to improve throughout the three-month intervention period. Each data element rate improved from low to mid 70 percent accuracy to 95 percent accuracy in month one and sustained 100 percent accuracy in months two and three.
- For the FQHC claim type, RMHP Prime reported an improvement in all five data elements, four of which improved immediately to 100 percent accuracy and sustained 100 percent accuracy for all three months. The *Procedure Code* data element had the most notable improvement; its rate increased 9.6 percentage points in month one and continued to improve to 100 percent accuracy in month two and sustained 100 percent accuracy by the end of the intervention.

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

HSAG found the following opportunities for improvement:

- For the professional services claim type, RMHP Prime requested 20 records per month from the provider; however, the MCO received no records after issuing multiple written and verbal requests to the pilot partner. This resulted in a reported 0 percent accuracy in all five data elements throughout the three-month intervention period.
- Five out of the 15 data elements for the QUIP that did not exceed 90 percent accuracy by the end of the project were all under the professional services claim type and scored 0 percent accuracy due to the pilot partner not submitting medical records. Overall, the pilot partner experienced notable difficulties submitting audit records; causes included both internal and external factors, such as third-party vendors who maintain and compile records for these types of audits.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Follow-Up on FY 2021–2022 QUIP Recommendations

FY 2021–2022 QUIP Recommendations

HSAG recommended that RMHP Prime continue communication with individual providers to ensure it is able to consistently receive complete and timely medical records.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 QUIP Recommendations

RMHP Prime determined a lack of responses to medical records requests was the contributing factor to low accuracy rates, and RMHP Prime reportedly took steps to improve provider response rates for the FY 2022–2023 Annual MCO Encounter Data Quality Review. Additionally, RMHP Prime reported engaging in various program integrity activities for purposes of identifying and educating providers on billing, coding, and documentation standards. RMHP Prime took steps to improve provider response rates. RMHP Prime responded to each component of HSAG's FY 2021–2022 QUIP recommendations. HSAG recognizes that education and improvements to provider response rates will likely result in better encounter accuracy rates.

Mental Health Parity Audit

Table 4-154 displays the MHP Audit compliance scores for RMHP Prime for FY 2022–2023 compared to the FY 2021–2022 compliance scores.

Table 4-154—FY 2022–2023 MHP Audit Score for RMHP Prime

MCO	FY 2021–2022 Total Score	Category of Service	Compliance Score	FY 2022–2023 Total Score
MH/SUD and M/S Services				
RMHP Prime	89%	Inpatient	100%	100%^
		Outpatient	100%	

^ *Indicates that the score increased as compared to the previous review year.*

RMHP Prime: Strengths

Based on MHP Audit activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP Prime:

- RMHP Prime demonstrated an overall score of 100 percent, an 11 percentage point increase from FY 2021–2022.
- RMHP Prime used nationally recognized UR criteria, including MCG, for all MH determinations and ASAM LOC criteria for all SUD determinations.
- RMHP Prime followed policies and procedures regarding IRR testing and required UM staff to participate in IRR testing annually, including requiring a minimum passing score of 80 percent.
- RMHP Prime 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.
- All 10 inpatient and 10 outpatient records reviewed indicated that RMHP Prime made the denial determination within the required time frame and providers were notified of the denial determinations through a phone call or email and received a copy of the NABD.
- All records reviewed demonstrated that RMHP Prime sent the member NABDs within the required time frame.
- In all records reviewed, the denial determination was made by a qualified clinician, and applicable cases contained evidence that RMHP Prime offered a peer-to-peer review to the requesting provider.
- RMHP Prime followed policies and procedures regarding attempting to reach out to the requesting provider for additional information due to lack of adequate documentation to determine medical necessity.
- All NABDs contained information about the reason for the denial that was consistent with the reason documented in RMHP Prime's UM system.
- RMHP Prime's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP Prime when filing, access to pertinent records, and the reason for the denial. Additionally, all NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
- During the MHP interview, RMHP Prime reported continued training and education for providers regarding ASAM LOCs and how to submit proper and thorough documentation requests for review. RMHP Prime included ASAM training videos on the website and provided more direct virtual

training opportunities with providers regarding administrative documentation needs to ensure sufficient and complete requests for authorizations.

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

HSAG found the following opportunities for improvement:

- Some NABDs listed the requested service date as the date the denial determination was made. Per guidance from the Department and as a best practice, the date the MCE denied the request should be the date of the denial determination for a new request for service or the date the current authorization expires (of the first non-authorized date) for concurrent/continued requests.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Conduct staff training and update the NABD template to ensure language regarding the date of the denial determination is used correctly.
- Work with the Department for additional assistance and guidance to ensure that the NABDs are clear and cohesive for the member.

Follow-Up on FY 2021–2022 MHP Recommendations

FY 2021–2022 MHP Recommendations

In FY 2021–2022, HSAG recommended RMHP Prime:

- Ensure UM staff members are aware of 42 CFR 438, which allows contracting for a 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.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 MHP Recommendations

RMHP Prime reported addressing HSAG's recommendations by:

- Continuing to review for the member's medical necessity and consider continuity of care for out-of-network provider authorization requests. While RMHP Prime is aware of the 120-calendar-day grace period, RMHP Prime decided to pursue other means of ensuring continuous care and member services with in-network providers. This includes providing contact information for in-network providers after an out-of-network denial is issued to the member within the NABD.

- Reminding UM staff members of the requirement to document that the peer-to-peer review was offered to a provider. The requirement is also listed in the RMHP Prime policy, and both BH and UM teams conduct monthly audits on cases to ensure that this policy is followed consistently.
- Training UM staff members about which template to use for the NABDs. RMHP Prime reported that both BH and PH UM teams conduct monthly audits on cases to ensure the correct template is used consistently.

HSAG anticipates RMHP Prime's responses to the recommendations are likely to improve overall processes and increase MHP compliance. HSAG encourages working with out-of-network providers for continuity of care purposes and assisting the member with transitioning over to an in-network provider, when needed. Additionally, RMHP Prime should continue addressing the recommendations made by HSAG for continuous improvement and staff enrichment.

QOC Concern Audit

The QOC Concern Audit was not conducted with RMHP Prime in FY 2022–2023.

Follow-Up on FY 2021–2022 QOC Concern Recommendations

FY 2021–2022 QOC Concern Recommendations

In FY 2021–2022, HSAG recommended RMHP Prime:

- Develop and implement ongoing staff training on the Colorado-specific QOC grievance 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 QOC grievances.
  - Incorporate contract requirements.
  - Add severity levels and definitions.
  - Include a process for reporting to the Department.
  - Incorporate a process for acknowledgement and resolution letters.
  - Establish milestones/timelines/time frames and/or goals for the QOC grievance process.
- Consider consistently requesting evidence of CAP completion from a facility/provider when a CAP is initiated. For example, if the facility indicated that it revised a policy and provided staff training, HSAG recommended RMHP Prime request a copy of the updated policy, training materials, and list of attendees.
- Continue notifying the Department of QOC grievances received. Additionally, HSAG recommended RMHP Prime 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. HSAG recommended RMHP Prime establish a process for sending acknowledgment and resolution letters to the party reporting the QOC grievance for all QOC grievances, regardless of who reported the QOC grievance referral.
- Follow up with its contract managers at the Department to resolve questions regarding whether RMHP Prime should conduct QOC grievances that are related to dental services since RMHP Prime is not the payor for dental services.

Assessment of RMHP Prime's Approach to Addressing FY 2021–2022 QOC Concern Recommendations

RMHP Prime reported addressing HSAG's recommendations by:

- Updating and finalizing policies and procedures for the QOC grievance process.
- Reviewing QOC activities and processes at the Medical Peer Review Committee and QIC.
- Dedicating a staff member to liaise between the appeal and grievance teams and medical director.
- Alerting and consulting the Department for the processing and resolving of any issues that arise involving dental services.
- Sending monthly closed case lists to the Department to provide visibility. RMHP Prime reported that all alerts are provided in real time for escalated concerns.

HSAG anticipates RMHP Prime's responses to the recommendations are likely to improve overall processes and alignment with contractual requirements. RMHP Prime should continue addressing the recommendations made by HSAG and prepare for guidance from the Department for upcoming contractual changes and requirements.

Appendix A. MCO Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for MY 2022 for measures with a hybrid option, along with the percentile ranking for each MY 2022 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 2022 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Cervical Cancer Screening			
Cervical Cancer Screening	34.24%	39.42%	<25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	68.09%	91.24%	≥90th
Counseling for Nutrition—Total	73.10%	83.21%	75th–89th
Counseling for Physical Activity—Total	71.96%	81.27%	≥90th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	77.26%	80.78%	10th–24th
Postpartum Care	69.45%	76.64%	25th–49th
Care of Acute and Chronic Conditions			
Controlling High Blood Pressure			
Ages 18 to 64 Years	47.93%	53.24%	—
Ages 65 to 85 Years	56.64%	50.70%	—
HbA1c Control for Patients With Diabetes*			
HbA1c Control (<8.0%)—Ages 18 to 64 Years	44.94%	53.14%	—
HbA1c Control (<8.0%)—Ages 65 to 75 Years	51.44%	54.10%	—
HbA1c Poor Control (>9.0%)—Ages 18 to 64 Years	45.15%	37.14%	—
HbA1c Poor Control (>9.0%)—Ages 65 to 75 Years	37.77%	36.07%	—

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

— indicates that the rate was not comparable to benchmarks.

Table A-2 shows RMHP Prime's rates for MY 2022 for measures with a hybrid option, along with the percentile ranking for each MY 2022 hybrid rate.

Table A-2—MY 2022 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Cervical Cancer Screening			
Cervical Cancer Screening	42.38%	56.63%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	23.40%	85.28%	75th–89th
Counseling for Nutrition—Total	25.96%	82.68%	75th–89th
Counseling for Physical Activity—Total	13.19%	77.92%	75th–89th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	49.83%	93.70%	≥90th
Postpartum Care	36.32%	84.81%	≥90th
Care of Acute and Chronic Conditions			
Controlling High Blood Pressure			
Ages 18 to 64 Years	22.00%	68.67%	—
Ages 65 to 85 Years	23.06%	62.86%	—
HbA1c Control for Patients With Diabetes*			
HbA1c Control (<8.0%)—Ages 18 to 64 Years	32.65%	51.71%	—
HbA1c Control (<8.0%)—Ages 65 to 75 Years	40.00%	7.07%	—
HbA1c Poor Control (>9.0%)—Ages 18 to 64 Years	61.39%	27.07%	—
HbA1c Poor Control (>9.0%)—Ages 65 to 75 Years	52.31%	2.44%	—

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

— indicates that the rate was not comparable to benchmarks.