COLORADO
Department of Health Care Policy & Financing

2024 Quality Strategy Evaluation & Effectiveness Review

Health First COLORADO™
Colorado's Medicaid Program

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Section 1: Introduction

Overview

In accordance with 42 CFR 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e) Health First Colorado (Colorado's Medicaid program) as administered by the Department of Health Care Policy & Financing (the Department, or HCPF), is pleased to present our written evaluation and effectiveness review for assessing and improving the quality of managed care services. Health First Colorado, which is funded jointly by a federal-state partnership, administers coverage to approximately 1.7 million Coloradans and serves as a national model for implementing an innovative Fee-for-Service (FFS) and managed health care system for managing costs, utilization, and quality.

Purpose

The purpose of this document, in accordance with §432.202(d), is to assess and illustrate the effectiveness of the Department's Quality Strategy, revisions, and modifications to those strategies when significant change occurs pursuant to any new regulatory reference at §438.340(b)(11) and/or amended federal/state regulations, changes to Department programs, policies, and procedures, or based on the Department's data analytics highlighting the need for change. At a minimum, the Department Quality Strategy is updated every three years. Reviews include an evaluation of the effectiveness of the Quality Strategy using data from multiple data sources.

The Department's Quality Strategy is published to our website for public comment and takes public recommendations into consideration for updating the Quality Strategy.

The Evaluation and Effectiveness Review is conducted by the Department whenever the Department's Quality Strategy is updated to evaluate the quality strategies for effectiveness. The prior review is published to our website and can be referenced here 2021 Evaluation and Effectiveness Review.

Section 2: Evaluation of Effectiveness

Goals and Objectives of Colorado's Managed Care Program

The Department, in alignment with the Governor's health care priorities, continues to focus on reducing health care costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive primary and behavioral health services for the Medicaid and Child Health Plan Plus (CHP+) population, based on the following mission, goals and associated performance measures.

> HCPF 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.

Strategic Pillars
HCPF manages projects under six pillars, to achieve Executive Leadership Team individual goals and Department goals, Governor's WIGs and the Health Cabinet WIGs. The pillars have been a cornerstone of achieving our strategic plan and are refined to best capture and ensure HCPF focuses on the most important work. Since the last issuing of this report, the Department's strategic pillars have grown. Employee Satisfaction and Equity, Diversity and Inclusion, and Care Access were added as strategic pillars.

The Department's six strategic pillars, designed to ensure customer-focused performance management, are as follows:

- Member Health: Improve quality of care and member health outcomes while reducing disparities in care.
- Care Access: Improve member access to affordable, high-quality care.
- Operational Excellence and Customer Service: Provide excellent service to members, providers and partners with compliant, efficient, effective person- and family-centered practices.
- Health First Colorado Value: Ensure the right services, at the right place and the right price.
- Affordability Leadership: Reduce the cost of health care in Colorado to save people money on health care.
- Employee Satisfaction: Invest in HCPF employees at all levels while improving equity, diversity, inclusion and accessibility

Goals
All Department goals are tied back to one of these strategic pillars. The Department is highly accountable for performance measures due to an annual performance measurement system. The Governor has annual performance goals for the Department, the Governor's Health Cabinet has annual performance goals for the Department, and the Department also has its own annual performance goals.

- All performance goals align with the Department's strategic pillars, and the performance plans are publicly available on the Governor's Operations website.
- Department performance is managed through Governor Office goals called Wildly important Goals (WIGs). The last six years of WIG are all available on the Governor's Dashboard.
- In addition to Governor's goals for the Department, the Department crafts goals and executes projects to reach the Department goals. The most recent year's performance strategy (FY 2025-26) has more than 95 projects to reach 45 goals.

Table 1: FY 2024-25 Strategic Pillars with Subset of Priorities

Member Health	Care Access	Operational & Service Excellence	Health First CO Value	Affordability Leadership
*Support health related social needs like housing and food security *Transform behavioral health and improve care for high acuity children and youth *Improve health equity in prevention, maternity care, behavioral health *Improve child/youth immunizations and prenatal care	*Keep Coloradoans covered *Expand coverage (1115, Cover All Coloradoans) *Protect member coverage, benefits, and services * Expand provider network, incl. behavioral health, specialists, rural, dental *Regularly review provider reimbursement rates to ensure access to care *Transform HCBS services for people with disabilities	*Improve eligibility systems, experience, county workload, automation, letter clarity *Resource counties *Stabilize LTSS ecosystem for people with disabilities *Drive service quality across all partners (calls/claims) *Innovate systems; smoothly implement system changes; bolster cyber security *Maximize and close-out ARPA funding	*Address Medicaid costs and trends *Modernize Medicaid delivery system through ACC Phase III *Advance value-based payments to drive quality, equity, access, and affordability *Right care, right time, right place, right price *Ensure appropriate Medicaid payments balancing provider admin *Prevent avoidable ER visits and hospital care	*Manage within difficult state budget limitations *Reduce uninsured rate *Mitigate rising pharmacy cost trends *Increase hospital affordability and price transparency (tools, reports, and policies) *Drive innovation through (eConsults, Prescriber Tools, SHIE, cost and quality indicators) *Lead value-based payments across payers

Member coverage, access and customer service is a staple within Governor Wildly Important Goals (WIGs) and the Department's own performance goals. Since 2021, many measurable Governor WIGs and their sub-goals have been met. Below is a partial list of the Department's

performance measures pulled from the Governor's Dashboard. Specific information on all the fiscal year's Governor's WIGs can be found on the Governor's Dashboard.

- A FY 2020-21 WIG focused on member customer service and access. There were several measures to reach the goal of outperforming targets. The Department exceeded a 95% target (monthly results between 98.1% and 98.9%) in processing eligibility applications within 45 days. The Department exceeded (between 29 and 92 seconds) a target of 150 second or less call answer rates. The Department exceeded (10,854 new providers) a target of 10,000 new Health First Colorado providers.
- Several FY 2021-22 Department goals focused on eligibility technology supports supporting a WIG to increase the rate of automated eligibility renewals from 79% to 85%. The WIG was met with monthly results between 82% and 88%. The leading measures that drove the successful completion of the WIG were to add system capability to verify employment income through automation and to enhance the capacity to rapidly validate accuracy of current addresses through automation.
- One FY 2022-23 WIG was to increase the number of Coloradans service by primary care providers moving to more advanced Alternative Payment Models from 22,364 to 250,000. The Department well-surpassed this goal with 533,306 providers. The leading measures that resulted in the successful completion of the goal included executing RAE contracts and stakeholder engagement.
- Reflecting the needs of the time, one FY 2023-24 WIG was to ensure coverage for Coloradans through the end of the Public Health Emergency. The Department exceeded all goals. 56% of renewals were automated, exceeding the 40% target. 645,539 households received outreach regarding renewals and/or transitions to other coverage, exceeding the 500,000 target.

The Department is currently performing within FY 2024-25's performance year. WIGs include Medicaid Efficiency, Automating Member Coverage Renewals, and Increase Access to Prenatal Care. Initial reporting shows most measures on track for success.

Utilization Review:

§438.210 Coverage and Authorization of Services

The Department's Colorado PAR Program serves to provide the utilization management (UM) review of selected fee-for-service (FFS) benefits administered throughout various health care settings. Benefits include, but are not limited to audiology, diagnostic imaging, durable medical equipment, prosthetics, home health, laboratory services, medical-surgical, out of state providers, private duty nursing, pediatric behavioral therapies, pediatric personal care, speech therapy, physical and occupational therapy, and other FFS benefits utilized by members. The Department utilizes a Quality Improvement Organization (QIO) to provide Utilization Management services per the contracted agreements. The Department currently utilizes Acentra Health as the contracted QIO for UM functions within the Colorado PAR program.

A major component to administering the Colorado PAR Program (CO PAR Program) is continuously evaluating the effectiveness and consistency of the UM review process. Utilization trends can vary between benefits, which add a degree of nuance to the evaluation process. However, a baseline set of metrics for evaluation would include turnaround times, authorization denial rates, authorization approval rates, cost-related data, industry performance standards, and stakeholder insight. In order to determine success and effectiveness, the department and UM vendor regularly monitor data trends for policy insight and process improvement opportunities. The evaluation process is a cross-collaborative effort between the contracted UM vendor, department staff, the stakeholder community, and systems partners. Various data metrics are utilized to identify unusual utilization trends, identify abrupt changes in utilization rates, monitor turnaround times, and review medical necessity determinations across the different benefits.

Since 2020, the prior Public Health Emergency (PHE) has since ended. During the PHE, utilization trends varied across industries as emerging challenges and policy priorities shifted. Nonetheless, as of 2024 the CO PAR Program's overall denial rate was 7.2%. The program's turnaround times for 2024 ranged between 1.2 business days to 4.5 business days. The department currently requires the average TAT be less than 10 business days. The future state of the CO PAR program is adjusting to various upcoming UM policy changes. The department continues to seek opportunities to implement initiatives to reduce provider burden, enhance system efficiencies, and address health equity.

CHP Dental Benefit – DentaQuest

Rising cost in healthcare has created a need to accurately assess quality and efficiency in oral care. Establishing measures to identify and monitor innovative strategies to reduce incidents of oral disease while driving improvement on performance-based outcomes is an important Department priority. To effectively measure oral care the Department utilizes data from various administrative sources (encounters and claims), patient records, and surveys which assist the Department in making policy decisions, based on identified key performance measures. For FY 2021-24 the Department focused on the following Dental performance measure:

How many children received at least one dental care service during the reporting fiscal year.

Results of CHP+ Measure CMS CARTS Report (Overall Utilization – Percentage of Members Receiving Any Dental Service) illustrated in Table 2, below.

Table 2: Overall Utilization

Fiscal Year	0-1 year	1-2 years	3-5 years	6-9 years	10-14 years	15-18 years	Total
FY 2021-22	6	490	3,041	6,678	8,477	5,557	24,249
FY 2022-23	72	1,174	4,563	9,756	11,661	7,020	34,246
FY 2023-24	124	3,986	8,241	12,785	14,681	9,221	49,038

Measure performance reflects an increase in all years from FY 2021 through FY 2024.

The Department's current CHP+ Contractor (DentaQuest) has active member outreach efforts in place to further drive performance improvement on this goal, including the development and distribution of electronic resources on oral health for children and families, virtual presentations (in urban, rural and frontier communities) to members and community partners on CHP+ dental benefits, the importance of oral health and how to access care during the pandemic, and coordination with dental providers across the state to ensure members receive timely and accurate information about their dental benefits.

Fiscal Year 2021 PIP Aggregate Summary Report

- Plan Name: DentaQuest
- Plan Type: PAHP
- PIP Topic: Percentage of all children enrolled under the age of 21 who received at least one dental service within the reporting year
- SMART Aim Statement: By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members age 3-5 who reside in Weld County from 45.47% to 49.30%
    - Mod 1: Completed
    - Mod 2: Completed
    - Mod 3: In Progress
    - Mod 4: Not Yet Initiated

- Confidence Level: TBD in FY 2023

Fiscal Year 2022–2023 PIP Activities

Table 3: SMART Aim Results (Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year)

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved?
The percentage of members who received any dental service among members ages 3-5 who reside in Weld County	45.47%	49.30%	59.86%	Yes

Table 4: Intervention Testing Results (Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service within the Reporting Year)

Intervention Description	Type of Improvement (demonstrated by Intervention Evaluation Results)	Final Intervention Status
Free online provider training on preventing early childhood dental care, with continuing education credits offered to dentist in Weld County	No improvement	Abandoned
Outreach with incentives offered to members and their caregivers to seek dental services by offering appointment scheduling assistance and a backpack with age-appropriate oral health materials for completing the visit.	Significant clinical improvement	Adapted

Based on the validation findings, HSAG assigned the Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year PIP a level of High Confidence.

Medicaid Measures

Percentage of Members who had at least one dental visit and one PCP visit in the reporting year.

The correlation between oral health and systemic health have been well established. Oral health impacts chronic health conditions such as diabetes and cardiovascular disease. In an effort to promote continuity of care, DentaQuest is tasked with increasing the percentage of child and adult members who have at least one dental visit and one primary care visit (PCP) in the reporting year.

- Tier 1 goal is to increase by 2% from baseline.
- Tier 2 goal is an increase of 5% from baseline.
- Tier 3 goal is an increase of 8% from baseline.
- Baseline percentage for each fiscal year is the final calculated percentage for the fiscal year prior.

Table 5: Dental and PCP Visit Results

Performance Measure	FY 2020-21	FY 2021-22	FY 2022-23
Members with one dental visit and one PCP visit	21.73%	24.82%	25.54%

The baseline for FY 2020-21 was 24%. The impact of COVID-19 during this year crippled the ability of most dental offices to provide care. This resulted in a decrease in the number of members who saw both their PCP and dental provider during this fiscal year.

In FY 2022, DentaQuest used targeted interventions to increase the number of members who had a PCP and dental visit. Outreach to families with more than one child in the household who were due for a dental exam resulted in positive results. Members who lived in areas with plenty of access were also encouraged to see their dental providers. This type of outreach resulted in an increase of 3.09% meeting the Tier 1 goal.

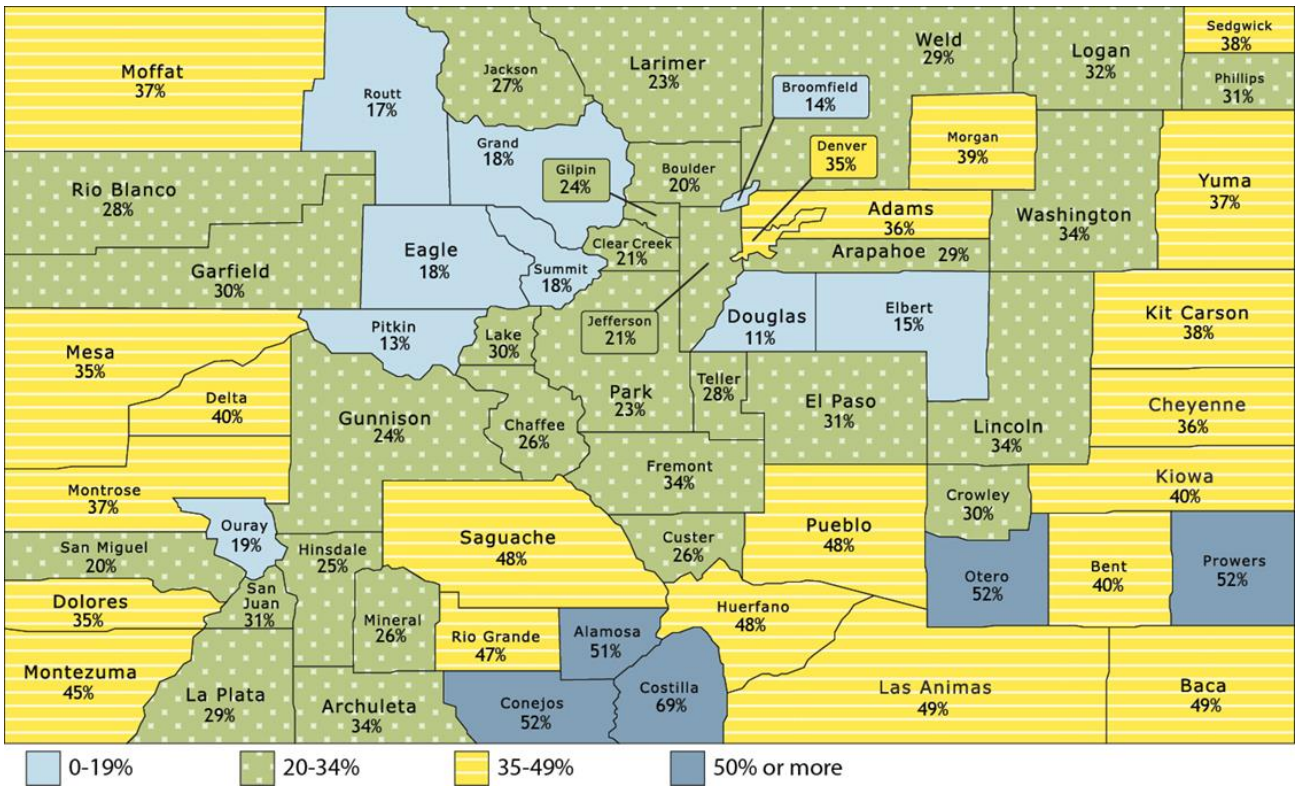
DentaQuest continued to work on the PCP and dental visit goal for FY 2022-23. The year over year increase continued and the final percentage of members who had both a PCP and dental visit was 25.54%. This was a 0.72% increase which did not meet the tier 1 goal.

There remain opportunities for improvement with this goal and DentaQuest will continue working on increasing the number of members who have had a dental and PCP visit.

The Department's current CHP+ Contractor has active member outreach efforts in place to further drive performance improvement on this goal, including the development and distribution of electronic resources on oral health for children and families, virtual presentations (in urban, rural and frontier communities) to members and community partners on CHP+ dental benefits, the importance of oral health and how to access care during the pandemic, and coordination with dental providers across the state to ensure members receive timely and accurate information about their dental benefits.

Member Demographics

County Map Population CY 2023; Percentage of total population enrolled in Health First Colorado and CHP+



The source of enrollment data is Medicaid Management Information System (MMIS). Percentages represent people enrolled for one day or more during calendar year 2023. 2023 population data as forecasted by the state demographer.

Enrollment and Disenrollment

In accordance with §438.56 the Department ensures enrollment and disenrollment services are compliant with federal and state regulations. The Department's Enrollment Broker strives to improve the quality and efficiency of customer service for enrolling members by integrating technology in its processes and using data to increase efficiency and performance based on the identified performance measures.

Section 3: Assessment Activities

Reducing Disparities in Health Care

The Department's person-centered work has always prioritized awareness and recognition of the impacts of social determinants of health on outcomes for the culturally diverse communities our programs serve. Department workgroups have prioritized data collection to address racial health disparities related to maternal and infant health and diabetes care. The

Department is developing an internal plan to address health disparities. Addressing health care disparities first requires the ability to accurately measure where a health disparity exists.

The Department is addressing health care disparities by refining data collection and systems on member and provider demographics, particularly race and ethnicity. This approach allows the Department and researchers to better disentangle factors that are associated with health care disparities. Further, collecting and analyzing patterns of health care by patient race, ethnicity, and other demographic data can help the Department to monitor the quality of care provided by its provider network. Such monitoring ensures accountability to enrolled members, improve member choice, and allow for evaluation of intervention programs. Focusing on data equity enables the Department to condition value-based payments to providers on evidence that they are improving health outcomes where disparities currently exist and enable new quality measurement that better allows the Department and providers to improve health disparities. Specifically, the Department seeks to:

- Address gaps in Medicaid application and claims data collection and analysis.
- Collect and analyze racial and ethnic disparities data from provider electronic health records systems (EHR), which includes information on clinical data and social determinants of health, such as food insecurity and housing.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.
- Enhance internal data analytics and health equity capacity to guide equity-focused, data informed and evidence-based programmatic interventions to improve health outcomes for marginalized and underserved communities.
- Develop and implement health equity lens or framework to evaluate the Department's policies, systems, programs and services.

The Department has already initiated conversations with both of Colorado's Health Information Exchange (HIE) organizations – Colorado Regional Health Information Organization and Quality Health Network (QHN) on the western slope – and they are providing the Department with options to merge their demographic data with our Medicaid data. The Department is beginning similar conversations with the state's All Payers Claims Database (APCD) and the Department of Public Health and Environment (CDPHE). By leveraging all available data sources, we can expand the Department's demographic markers, the accuracy of measuring where health disparities exist, and cause the potential solutions to increase.

The Department is uniquely positioned to incentivize Medicaid providers to capture demographic and clinical information from their patients and to build the interfaces to collect the data. The Department invests in HIE infrastructure that allows Medicaid providers and hospitals to securely connect their individual EHR systems with other systems through the health information exchange network.

Using enhanced federal funding, the Department has overseen the connection of over 300 clinics and 90 hospitals' electronic health records (EHRs) to Colorado's HIE organizations which cover over 6,300 providers and more than 6.5 million patients (including out-of-state visitors). The Department seeks to maintain these funds to continue connecting providers to the HIE and maintain this flow of information. Further, the Department can leverage enhanced federal funding to establish regular data feeds with these external databases to integrate demographic data into the Department's existing data warehouse. Once the data feeds and processes for merging data have been established, the same process can be duplicated so demographic data in the state's APCD can be expanded. That larger data set can be leveraged to address health care disparities statewide, beyond Medicaid.

Advancing Health Equity at the Department

The Department's approach to addressing health disparities is anchored in the tenet of ensuring high quality care and services for the people Medicaid serves. Our role as the Medicaid payer in Colorado's health care ecosystem affords the Department the lever to maximize health care investments in underserved and underrepresented communities by working collaboratively with partners to identify and remove obstacles to access and utilization among historically marginalized populations.

In accordance with the Governor Polis' Executive Order D2020-175, the Department is developing an Equity, Diversity, and Inclusion Plan that explicitly addresses nine EDI topic areas. Topic areas pertaining to health equity are highlighted below.

Long-Term Plan and Reporting. To create and continuously update a long-term plan to identify and address barriers as well as metrics to evaluate progress, Department activities will focus on:

- Convening an internal, employee-led workgroup dedicated to advancing health equity among Colorado Medicaid members.
- Developing a health equity lens or framework to guide decision-making across the Department.

Community Engagement. This topic area calls upon agencies to involve community partners in decision making from the beginning to end of projects, as well as measuring equity, diversity and inclusion efforts on state boards and commissions appointed by the Governor's Office. In our focus on health equity, the Department intends to engage with Medicaid stakeholders and partners by:

- Cultivating meaningful and respectful dialogue on equity and diversity issues with
    - Medicaid members, providers, advocacy groups and other stakeholders

    - Engaging member and provider advisory groups in the work of health equity
- Allowing space for regional or geographic differences in defining diversity and equitable health outcomes for diverse Colorado communities
- Intentionally seek feedback from stakeholders about the emerging Department health equity lens or framework

Policy, System, Program, and Services Review. To abide by the expectation that agencies shall review, acknowledge, and dismantle any inequities within agency policies, systems, programs, and services, and continually update and report agency progress, the Department's health equity work will be guided by a focus on data analytics for the Medicaid population to include:

- Identify disparities data among marginalized, underrepresented and underserved communities across the state.
    - Examples: racial and ethnic disparities in Medicaid enrollment, primary care utilization, emergency department admissions, specific diagnostic and treatment codes.
    - Data challenges from Medicaid claims data, as well as electronic health records systems (e.g., gaps in self-reported data).
- Data analytics will focus on ability, race and ethnicity, gender, language, national origin, sexual orientation, and other protected classes.
    - Highlight a focus on intersectionality, for example, specific health disparities linked to race and gender; ability and gender; language and race.
- Acknowledge different conceptualizations of diversity by region and/or geography.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.

Alignment with CDPHE's Health Equity Efforts. The Department's efforts to address health disparities and advance equity, diversity, and inclusion are aligned with equity-focused guidelines and principles championed by the Colorado Equity Alliance, a cross-agency group founded by staff of the CDPHE's Office of Health Equity. The alliance, comprised of representatives from both state agencies and community organizations, aims to operationalize equity and make sure it is woven into the fabric of state governance. The Department is represented in the core committee of the Colorado Equity Alliance. The CDPHE's Health Disparities Program is focused on preventing targeted conditions (e.g., cancer, cardiovascular/pulmonary disease) through upstream investments in social determinants such as housing.

National Performance Measures

§438.204(c)

At this time, Centers for Medicare and Medicaid Services (CMS) has not identified any required national performance measures. However, CMS has developed a voluntary set of core performance measures for children and adults in Medicaid and CHIP. Many of these measures have already been in widespread use as part of the Healthcare Effectiveness Data and Information Set (HEDIS)® and have readily available national and regional benchmarks.

The Department reviews and selects HEDIS® measures for reporting each year to evaluate performance in terms of clinical quality and customer service. Measures are identified and selected annually using input from Department contractors, the External Quality Review Organization (EQRO), and Department staff. The Department is currently working to implement software that will enable HEDIS® reporting for the entire Health First Colorado population. Although CMS has not identified a list of required national performance measures, the Department has voluntarily reported a subset of the Adult and Child Core Set Measures to CMS annually. The Department continues to identify areas of opportunity for driving performance improvement and will report a select set of the CMS Adult and Child Core Measures in relation to identified national benchmarks in calendar year 2021-2023. The Department strategically focused on key deliverable effectiveness and assessment performance measures for calendar year 2021-2023: Primary Care Access and Preventative Care, Contraceptive Care, and Adolescents. Primary care access and preventative care performance results are illustrated in Table 6, below:

Table 6:Performance Results

Performance Measures	MY 2021	MY 2022	MY 2023
Well-Child Visits in the First 30 Months of Life – First 15 months	48.77%	61.60%	63.34%
Well-Child Visits in the First 30 Months of Life – 15-30 months	43.46%	58.57%	61.02%
Child and Adolescent Well-Care Visits	34.86%	39.83%	44.99%
Cervical Cancer Screening	35.17%	33.46%	34.73%
Chlamydia Screening in Women Ages 21 to 24	52.57%	51.06%	55.57%
Colorectal Cancer Screening			20.35%
Breast Cancer Screening	33.50%	34.79%	36.21%

Well-child visits are critical checkpoints to assess the health and development of pediatric members throughout their early years and into adolescence. The Department has been consistently improving year over year on both well-care visits. Screenings have also been an important focus and the improvements in performance are seen by end of measure year 2023. The Department has been and will still include these measures in its 2024 Primary Care APM to incentivize providers to focus on this area of primary access and preventive care.

Contraceptive Care

Table 7: Contraceptive Care Performance Results

Performance Measures	MY 2021	Performance Measures	MY 2022	MY 2023
Contraceptive Care – Postpartum Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception within 3 days of Delivery	8.66%	Contraceptive Care – Postpartum Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception within 3 days of Delivery	8.39%	9.03%
Contraceptive Care – Postpartum Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception within 60 days of Delivery	30.58%	Contraceptive Care – Postpartum Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception within 90 days of Delivery	34.61%	35.88%
Contraceptive Care – All Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception	19.60%	Contraceptive Care – All Women Ages 21 to 44 *Most effective or Moderately Effective method of Contraception	17.57%	16.28%

The Department's focus on contraceptive care has yielded positive results for the postpartum population. Contraceptive care is a measure in multiple efforts including the ACC Performance Pool, the Maternity Condition Management Program, Maternity Value Based Payment Program, APM program and the Hospital Transformation Program.

Maternal and Perinatal Health

Table 8:Maternal and Perinatal Health Performance Results

Performance Measures	MY 2021	MY 2022	MY 2023
Prenatal and Postpartum Care: Postpartum Care	45.91%	47.37%	55.96%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	56.81%	60.80%	65.21%

Behavioral Health Care

Table 9: Behavioral Health Care Performance Results

Performance Measures	MY 2021	MY 2022	MY 2023
Initiation and Engagement of Substance Use Disorder Treatment – Initiation	N/A	37.69%	60.94%
Initiation and Engagement of Substance Use Disorder Treatment – Engagement	N/A	13.42%	35.06%
Antidepressant Medication Management - Acute	67.42%	67.01%	68.23%
Antidepressant Medication Management - Chronic	45.56%	44.32%	45.73%
Screening for Depression and Follow-Up Plan: Age 18 and Older	N/A	N/A	16.94%

Follow-Up After Hospitalization for Mental Illness: Age 18 and Older – 7 day Follow Up	N/A	22.02%	27.17%
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older -30 day Follow Up	N/A	36.77%	43.17%
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 – 7 day Follow Up	N/A	36.88%	44.84%
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 – 30 day Follow Up	N/A	56.82%	63.85%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.92%	76.93%	78.83%
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older – 7 day Follow up	N/A	26.92%	24.35%
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older – 30 day Follow up	N/A	38.57%	35.88%
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 – 7 day Follow Up	N/A	21.91%	17.09%
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 – 30 day Follow Up	N/A	30.87%	27.81%
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older – 7 day Follow Up	N/A	35.39%	36.63%
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older – 30 day Follow Up	N/A	49.33%	51.06%
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 – 7 Day Follow up	N/A	36.88%	44.84%
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 – 30 Day Follow up	N/A	56.82%	63.85%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.67%	63.52%	63.95%

Monitoring and Compliance
§438.204(b)(3)

Primary Care Alternative Payment Model

One of the primary objectives of the ACC is to ensure greater accountability and transparency. One way the Department looks to increase the transparency of the ACC is to share data on clinical and utilization measures used to monitor the program and its vendors. In addition, the Department shares data on social determinants of health metrics to highlight the roles Regional Accountable Entities (RAEs) play in supporting overall population health. These measures are important for tracking utilization of services and access to care.
The public reporting dashboard is designed to help the RAEs identify the health needs of their members on a population level and provide stakeholders with a means to hold the RAEs accountable for performance and quality improvement.

Annual public reporting of performance measures can be accessed here.

Key Performance Indicators (KPI's)

One of the primary objectives of the Department is to ensure greater accountability and transparency by sharing data on clinical and utilization measures that are used to monitor the ACC program and its vendors. Since the initiation of the ACC Program, the Department has made incentive payments for the performance on identified Key Performance Indicators (KPIs) to signal program-level goals and objectives; encourage improved performance at the PCMP and regional level; and reward RAE and managed care entities for meeting certain levels of performance. For FY 2023-2024 the Department focused on the following KPI's to assess the RAEs progress in building a coordinated, community-based approach for serving the needs of Health First Colorado Members while reducing costs and promoting the health and wellbeing within their respective regions. Each KPI calculation is based on the utilization of services by the population enrolled in the ACC. FY 2023-2024 calculations are as follows:

Table 10: Key Performance Indicators

Emergency Department PKPY					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	81,894	1,822,579	561.34	509.372	No Target Met
RAE2	61,485	1,033,958	675.289	616.426	No Target Met
RAE3	185,621	3,541,272	611.897	559.54	No Target Met
RAE4	82,929	1,494,541	544.565	471.357	No Target Met
RAE5	102,447	1,617,262	660.713	617.647	No Target Met
RAE6	85,995	1,813,423	534.226	471.931	No Target Met
RAE7	129,166	2,077,951	698.659	620.429	No Target Met
Child and Adolescent Well-Care Visits					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	24,616	49,999	49.23%	40.58%	Met Target Tier 2
RAE2	9,326	25,279	36.89%	33.96%	No Target Met
RAE3	43,554	89,555	48.63%	42.08%	Met Target Tier 2
RAE4	13,931	33,979	41.00%	36.48%	Met Target Tier 2
RAE5	19,032	37,433	50.84%	49.17%	No Target Met
RAE6	17,901	37,215	48.10%	40.08%	Met Target Tier 2
RAE7	19,075	46,670	40.87%	34.03%	Met Target Tier 2
Oral Evaluations					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	27,960	58,376	47.90%	49.29%	No Target Met
RAE2	15,212	29,669	51.27%	47.95%	Met Target Tier 2
RAE3	53,537	106,971	50.05%	51.22%	No Target Met

RAE4	18,587	38,724	48.00%	47.49%	No Target Met
RAE5	24,966	46,080	54.18%	54.73%	No Target Met
RAE6	21,556	43,698	49.33%	50.74%	No Target Met
RAE7	27,868	55,817	49.93%	49.36%	No Target Met
Depression Screening and Follow-Up Plan					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	7,735	36,588	21.14%	10.48%	Met Target Tier 2
RAE2	4,506	21,658	20.81%	16.82%	No Target Met
RAE3	20,435	77,933	26.22%	17.18%	Met Target Tier 2
RAE4	7,236	33,645	21.51%	17.44%	No Target Met
RAE5	8,949	35,399	25.28%	16.81%	Met Target Tier 2
RAE6	7,230	39,288	18.40%	14.71%	No Target Met
RAE7	12,555	38,334	32.75%	34.26%	No Target Met
Well-Child Visits - First 15 Months					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	1,603	2,427	66.05%	63.19%	Met Target Tier 2
RAE2	666	1,265	52.65%	58.02%	No Target Met
RAE3	2,911	4,732	61.52%	59.00%	Met Target Tier 2
RAE4	948	1,593	59.51%	57.12%	Met Target Tier 2
RAE5	1,778	2,784	63.86%	61.34%	Met Target Tier 2
RAE6	1,067	1,762	60.56%	56.77%	Met Target Tier 2
RAE7	1,367	2,220	61.58%	56.38%	Met Target Tier 2
Well-Child Visits - 15 to 30 Months					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	1,806	2,515	71.81%	65.15%	Met Target Tier 2
RAE2	762	1,279	59.58%	54.23%	No Target Met
RAE3	3,170	4,768	66.48%	61.96%	Met Target Tier 2
RAE4	1,058	1,630	64.91%	58.54%	Met Target Tier 2
RAE5	1,684	2,389	70.49%	64.90%	Met Target Tier 2
RAE6	1,247	1,914	65.15%	57.59%	Met Target Tier 2
RAE7	1,561	2,450	63.71%	56.83%	Met Target Tier 2
Timeliness of Prenatal Care					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	1,144	1,706	67.06%	51.13%	Met Target Tier 2
RAE2	1,052	1,552	67.78%	56.15%	Met Target Tier 2
RAE3	3,101	4,461	69.51%	65.31%	Met Target Tier 2
RAE4	1,263	1,860	67.90%	63.91%	Met Target Tier 2
RAE5	1,962	2,558	76.70%	73.05%	Met Target Tier 2
RAE6	1,369	1,932	70.86%	61.22%	Met Target Tier 2
RAE7	1,731	2,591	66.81%	58.81%	Met Target Tier 2
Postpartum Care					
RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description

RAE1	1,076	1,706	63.07%	40.29%	Met Target Tier 2
RAE2	1,018	1,552	65.59%	41.43%	Met Target Tier 2
RAE3	2,838	4,461	63.62%	47.46%	Met Target Tier 2
RAE4	1,222	1,860	65.70%	50.05%	Met Target Tier 2
RAE5	1,734	2,558	67.79%	53.98%	Met Target Tier 2
RAE6	1,298	1,932	67.18%	51.76%	Met Target Tier 2
RAE7	1,673	2,591	64.57%	39.01%	Met Target Tier 2

Risk Adjusted PMPM

RAE	Numerator	Denominator	Risk Adjusted PKPY	Risk Adjusted PKPY Baseline	Met Target Tier Description
RAE1	N/A	N/A	$530.88	$552.97	Met Target
RAE2	N/A	N/A	$462.89	$552.97	Met Target
RAE3	N/A	N/A	$598.35	$552.97	No Target Met
RAE4	N/A	N/A	$494.68	$552.97	Met Target
RAE5	N/A	N/A	$556.51	$552.97	No Target Met
RAE6	N/A	N/A	$554.05	$552.97	No Target Met
RAE7	N/A	N/A	$582.54	$552.97	No Target Met

Member Experience Surveys

Consumer Assessment of Health Providers and Systems (CAHPS)

The CAHPS surveys ask members questions about the service provided by their health plans. Results are used to inform health plans about how satisfied members are with the care they receive and where they need to improve. Beginning in fiscal year 2021–2022, the Department chose to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey instead of the Patient-Centered Medical Home (PCMH) Survey to adult and child members receiving services through Health First Colorado. By utilizing the CAHPS Health Plan Survey, the Department can meet mandatory reporting requirements set forth in the Adult and Child Core Sets. Additionally, changing the survey instrument means that the RAE level CAHPS survey results are more comparable to other health plans and statewide averages than the practice level PCMH survey results and provides the opportunity for national database submissions and benchmark comparisons, which became unavailable for the PCMH Survey beginning in 2021 when the Agency for Healthcare Research and Quality (AHRQ) suspended data submissions for the CAHPS Clinician & Group (CG-CAHPS) Survey Database. In fiscal year 2023-2024 The Department added the Children with Chronic Conditions (CCC) supplemental questions to child CAHPS surveys in order to meet core measure reporting requirements.

Adult Survey

Figure 3 shows the adult CAHPS results for the seven RAEs and the Colorado RAE Aggregate (i.e., combined results of the seven RAEs) for FY 2023–2024.

Figure 3 FY 2023–2024 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	56.80%	58.55%	65.93% ↑	58.04%	56.73%	50.37%	44.82% ↓	56.00%
Rating of All Health Care	41.24%+	59.02%+	54.98%	54.46%	55.09%	50.27%+	47.96%+	51.66%
Rating of Personal Doctor	60.74%	72.00%+	75.49%	65.93%	62.08%	64.75%	63.84%+	66.93%
Rating of Specialist Seen Most Often	57.55%+	65.01%+	59.83%+	53.10%+	67.05%+	56.72%+	64.47%+	60.19%
Getting Needed Care	78.21%+	89.54%+ ↑	80.80%	76.57%+	79.00%+	75.15%+	79.45%+	79.30%
Getting Care Quickly	87.26%+	84.39%+	81.38%+	80.72%+	77.89%+	78.92%+	76.46%+	80.51%
How Well Doctors Communicate	94.64%+	94.41%+	95.73%	91.99%+	93.48%+	91.35%+	90.73%+	93.18%
Customer Service	85.18%+	94.35%+	87.35%+	81.79%+	84.73%+	92.93%+	93.90%+	88.65%
Coordination of Care	87.26%+	86.56%+	87.33%+	77.41%+	77.78%+	83.65%+	81.84%+	83.28%
Advising Smokers and Tobacco Users to Quit	74.27%+	58.96%+	68.86%+	52.41%+	62.64%+	69.80%+	66.71%+	65.66%
Discussing Cessation Medications	43.59%+	39.32%+	46.77%+	37.93%+	42.39%+	42.88%+	41.11%+	42.60%
Discussing Cessation Strategies	38.01%+	35.09%+	42.01%+	39.23%+	49.49%+	42.39%+	44.69%+	41.87%

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 2023–2024 score is statistically significantly higher than the Colorado RAE Aggregate.
↓ Indicates the FY 2023–2024 score is statistically significantly lower than the Colorado RAE Aggregate.

For the adult population, the following three measures had the highest FY 2022-2023 scores compared to the other measures' scores:

- How well Doctors communicate (94.53%)
- Customer Service (89.18%)

- Getting Care Quickly (87.87%)

Child Survey

Figure 4 shows the general child CAHPS results for the seven RAEs and the Colorado RAE Aggregate (i.e., combined results of the seven RAEs) for FY 2023–2024.

Figure 4 FY 2023–2024 General 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	69.36%	62.92%	72.93%	67.92%	75.64% ↑	70.25%	60.19% ↓	69.13%
Rating of All Health Care	69.82%	61.01%+	69.73%	64.44%	72.46%	65.21%	57.83%	66.40%
Rating of Personal Doctor	75.41%	74.68%	69.78%	74.07%	79.85%	73.30%	72.25%	73.43%
Rating of Specialist Seen Most Often	58.47%+	73.78%+	60.77%+	74.93%+	74.09%+	65.56%+	61.97%+	65.25%
Getting Needed Care	82.59%	80.74%+	80.34%	85.50%+	83.91%	81.10%+	76.74%+	81.23%
Getting Care Quickly	85.77%	83.82%+	84.48%	86.78%+	85.30%	87.18%+	83.59%+	85.10%
How Well Doctors Communicate	95.08%	91.81%+	93.00%	93.04%	94.58%	94.62%	94.91%+	93.90%
Customer Service	87.03%+	87.43%+	89.72%+	84.58%+	87.68%+	88.52%+	91.40%+	88.50%
Coordination of Care	75.25%+	76.18%+	82.41%+	80.55%+	85.25%+	79.30%+	80.63%+	80.13%

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 2023–2024 score is statistically significantly higher than the Colorado RAE Aggregate.

↓ Indicates the FY 2023–2024 score is statistically significantly lower than the Colorado RAE Aggregate.

For the children population, beginning in FY 2022-2023 The Department started including the Children with Chronic Conditions (CCC) supplement within the CAHPS child survey. For the child population, the following three measures had the highest FY 2022-2023 scores compared to the other measures' scores:

- How Well Doctors Communicate (93.90%)
- Customer Service (88.50%)
- Getting Care Quickly (85.10%)

CCC Results

Figure 5 shows the CCC CAHPS Results for the Colorado RAE Aggregate (i.e., combined results of the seven RAEs) for FY 2023–2024.[1]

Measure	Colorado RAE Aggregate
Rating of Health Plan	62.62%
Rating of All Health Care	59.00%
Rating of Personal Doctor	72.28%
Rating of Specialist Seen Most Often	60.77%
Getting Needed Care	80.33%
Getting Care Quickly	87.87%
How Well Doctors Communicate	94.53%
Customer Service	89.18%
Coordination of Care	80.85%
Access to Specialized Services	70.11%
FCC: Personal Doctor Who Knows Child	91.61%
Coordination of Care for Children with Chronic Conditions	77.67%
Access to Prescription Medicines	87.28%
FCC: Getting Needed Information	90.29%

For the CCC supplemental measures the following three scores exceeded 80%.

- Personal Doctor Who Knows Child (91.61%)
- Access to Prescription Medications (87.28%)
- Getting Needed Information (90.29%)

The Department will continue to collaborate with the RAE's to develop statewide initiatives designed to improve member experience with their Health Plan, Health Care and Personal Doctor which provided the lowest scores from the survey for adults and children enrolled in Medicaid.

CAHPS Surveys – MCO Capitation Initiative

Figure 6 shows the adult Medicaid CAHPS results for DHMP and RMHP Prime for FY 2023–2024

[1] Due to a low number of respondents for the CCC population, HSAG is unable to present results at the RAE level for comparison to the Colorado RAE Aggregate in this report (i.e., the RAE-level results are not reportable).

Figure 6 – FY 2023–2024 Adult Medicaid CAHPS Results for MCOs

Measure	FY 2023-2024 DHMP Score	FY 2023-2024 RMHP Prime Score
Rating of Health Plan	56.58%	54.72%
Rating of All Health Care	51.74%	41.61%
Rating of Personal Doctor	73.10%	56.73%
Rating of Specialist Seen Most Often	63.11%	58.82%
Getting Needed Care	75.18%	85.24%
Getting Care Quickly	71.48%	79.32%
How Well Doctors Communicate	93.54%	90.91%
Customer Service	90.20%	92.86%+
Coordination of Care	90.20%	80.72%+
Advising Smokers and Tobacco Users to Quit	68.12%	66.34%
Discussing Cessation Medications	58.09%	50.00%
Discussing Cessation Strategies	49.63%	48.98%+

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.

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.

RMHP Prime is not required to submit child Medicaid CAHPS data for reporting purposes due to their small Managed Care population consisting of children with disabilities

For the adult statewide Medicaid population, overall, member experience scores for the MCOs' adult population have fluctuated, either increasing or decreasing slightly, across the years; however, the measures of How well Doctors Communicate, Customer Service and Coordination of Care all scored higher than 80%. The Department will continue to work with the MCOs to develop initiatives designed to improve member experience with their Health Plan, Health Care and Personal Doctor which provided the lowest scores from the survey.

For the child statewide Medicaid population, overall, member experience scores for the MCOs' child population have fluctuated, either increasing or decreasing slightly, across the years; however, How Well Doctors Communicate, Rating of Personal Doctor and Customer Service scored above 80% with the Children With Chronic Conditions scoring high in Personal Doctor Knows Child, Coordination of Care, Access to Prescription Medicines and Getting Needed Information as well. The Department will continue to work with the MCOs to develop initiatives designed to improve member experience with their Health Plan, Health Care and

Personal Doctor which provided the lowest scores from the survey for Adults and Children in Managed Care

National Core Indicators

The National Core Indicator (NCI) Survey provides an opportunity for members who receive Home and Community Based Services (HCBS) to report their satisfaction with their services, understand demographics of members, and address key areas of concern such as employment, respect/rights, service planning, community inclusion, choice, and health and safety. Colorado has been participating in the NCI surveys since 2013.

Important Note on Impact of COVID-19: It is important to note while viewing the data, that data may have been impacted due to the COVID-19 pandemic. In 2019-2020, NCI-IDD survey data collection period was unexpectedly abbreviated. National Core Indicators recommended states pause in-person surveying on March 16, 2020, and the NCI-IDD surveying ended in April due to the ongoing pandemic. The 2020-2021 NCI-IDD was conducted remotely with the person receiving services and/or their proxy (a person authorized to participate in the survey on behalf of another) via Zoom Video.

Similarly, the 2019-20 NCI-AD data collection period was unexpectedly abbreviated, and all data collection stopped in April. A national report of NCI-AD data comparing states was not released for this survey cycle, and only a state-specific report was released. In 2020-21, neither the state-specific nor national report was produced or released for the NCI-AD. The 2019-20 NCI Family Survey data collection cycle began July 1, 2019, and ended June 30, 2020. Data collection for the NCI Family Surveys continued throughout the pandemic. States begin data collection at various times throughout the year – some states began before the pandemic started, and some began after. Because the family surveys do not collect information on the date of survey completion, we cannot fully assess what impact the pandemic had on data collected at different times throughout the year.

In-Person Survey

In survey cycle 2023-2024, HCPF administered the In-Person Survey (IPS), also known as the Intellectual and Developmental Disabilities Survey or IDD. Members on the Developmental Disabilities (DD) and Supported Living Services (SLS) waivers were randomly selected from a list of Colorado residents receiving the long-term services and supports to participate. The survey sample was stratified by the 20 new defined services areas, in hopes of acquiring baseline data to track member satisfaction within the service areas along with the implementation of case management redesign and the phasing into the new Case Management

Agencies (CMAs). In previous years, the stratification of the sample was based on the member's RAE region.

Colorado launched the NCI-IDD survey in October 2023 using hybrid survey modes to include Zoom and in-person interviewing, and data collection closed in May 2024. In survey cycle 23-24, the completed survey target was expanded from 415 to 1,050. The survey interviewer team contacted 2,963 participants, with the team completing 1,053 surveys. The response rate for the project was 38.2%. Seventeen of the 20 defined service area targets were met except in Baca, Kiowa, and Prowers County (Area 2), Bent, Cowley, and Otero County (Area 3), and Clear Creek and Jefferson Counties (Area 7). Overall, the survey interviewer team had 276 guardian refusals and 181 member refusals to participate in the survey. The top refusal reasons were distrust (29), not able to participate (58), not interested (253), or too busy and had no time (97). Additionally, there were 82 no shows/canceled, 34 tech barriers, 37 staff barriers, 22 reports of participants deceased, 10 participants hospitalized, and 24 marked as other.

2023-24 NCI-IDD Data Reports:

The final data report for the 23-24 NCI-IDD survey cycle has not been released as of November 2024. Current NCI-IDD reports can be located on NCI's reporting website.

Aging and Disabilities

In survey cycle 2022-2023, HCPF administered the National Core Indicators-Aging and Disabilities (NCI-AD), an initiative designed to support states' interest in assessing the performance of their programs and delivery systems to improve services for older adults and individuals with physical disabilities. Members on the Complementary and Integrative Health Waiver (CIH), Brain Injury Waiver (BI), Community Mental Health Supports Waiver (CMHS), and the Elderly, Blind, and Disabled Waiver (EBD) were randomly selected from a list of Colorado residents receiving the long-term services and supports to participate.

Data collection was initiated on November 1st, 2022, utilizing hybrid survey modes to include phone, Zoom, and in-person interviewing, and concluded on May 19th, 2023. The interviewer team completed 1,295 surveys. The response rate for the project was 32.2%. Nineteen of the 21 catchment area targets were met except Chaffee County and Kit Carson County. The highest number refusal reason was "not interested" (428), followed by "too busy / no time" (126), and "distrust" (75).

2022-23 NCI-AD Data Reports:
2022-2023 NCI-AD National Report
2022-2023 NCI-AD National At-a-Glance Report
2022-2023 NCI-AD Colorado State Report

In the 2022 NCI-AD, 85% reported services help them live the life they want. This question was newly introduced in 2021, and there are no previous data points for comparison.

	2021	2022	NCI 2022
Average	86%	85%	87%
N	302	904	9,108

In the NCI-IDD, members reported needing more additional services regarding transportation, help working on job skills, help finding or signing up for classes, and help to find something different to do during the day (not including paid work).

In the NCI-AD, members reported needing additional services regarding housing assistance, companion services, transportation, home delivered meals, homemaker/chore services, and personal care assistance.

Additional Services Needed	2019*	2021	2022
Housing Assistance	32%	38%	20%
Companion Services	33%	27%	14%
Transportation	42%	38%	28%
Home Delivered Meals	24%	22%	20%
Homemaker/Chore Services	40%	45%	42%
Personal Care Assistance	23%	28%	24%

*2020 omitted due to COVID-19 pandemic

Upcoming Survey Cycles

The first year of reporting for the new HCBS Quality Measure Set (HCBS QMS) will be fall 2026, utilizing performance data from 2025 and requires data collection to begin in the 2024-25 NCI survey cycle. As such, HCPF is administering both the NCI-Aging and Disabilities (AD) and NCI-IDD surveys 24-25 survey cycle which launched in October 2024.

Monitoring for Compliance with Federal Healthcare Regulations

The Department's comprehensive quality improvement program strives to incorporate all departmental operational areas to monitor and ensure compliance with all state and federal regulatory requirements. This includes a review of the health plan's documents (e.g., policies and procedures, operational reports, provider and informational materials) and a visit to the health plan's site to interview key staff members and review administration records.

Compliance Monitoring Areas of Review in FY 2021-2024

Evaluation and effectiveness of compliance with Medicaid managed care regulations was designed to determine the RAE's compliance with contracts with the department, state and federal managed care regulation and related Department contract requirements. The Department's compliance monitoring measures how well each health plan complied with federal healthcare regulations and met the requirements of their contract with the Department. Compliance monitoring includes a review of the health plan's documents (e.g., policies and procedures, operational reports, provider and informational materials) and a visit to the health plan's site to interview key staff members and review administration records. Statewide results by plan, and Statewide RAE averages from FY 2021-2024 are listed below:

Figure 9: Statewide Compliance Monitoring Performance for RAEs

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%	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 (2023-2024)*	100%^	100%^	94%~	100%^	94%~	100%^	100%^	98%^
Standard VI—Grievance and Appeal Systems (2022-2023)	94%^	91%^	94%^	91%^	97%^	74%^	74%~	88%^
Standard VII—Provider Selection and Program Integrity (2023-2024)*	100%^	75%v	94%v	75%v	94%v	100%~	100%~	91%v
Standard VIII—Credentialing and Recredentialing (2020-2021)	100%	94%	100%	94%	100%	100%	100%	98%
Standard IX—Sub contractual Relationships and Delegation (2023-2024)*	75%~	50%v	25%v	50%v	25%v	75%v	75%v	54%v
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS) (2023-2024)*	100%~	100%~	100%~	100%~	100%~	100%~	100%~	100%~

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 XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021-2022)	100%~	86%	100%^	86%	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 2023-2024. Scores are compared across three years.*

v *Indicates an increase from review three years prior.*

~ *Indicates a decrease from review three years prior.*

Indicates no change from review three years prior.

Statewide Compliance Monitoring Results

Statewide trended performance for two MCOs included in the capitated Managed Care Initiative

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%	92%
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 (2023-2024)*	83%	100%	92%
Standard VI—Grievance and Appeal Systems (2022-2023)	80%	94%	87%
Standard VII—Provider Selection and Program Integrity (2023-2024)*	94%	100%	97%
Standard VIII—Credentialing and Recredentialing (2020-2021)	100%	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2023-2024)*	25%	75%	50%
Standard X—QAPI, CPGs, HIS (2023-2024)*	100%	100%	100%

Standard and Applicable Review Years	DHMP	RMHP Prime	Statewide MCO Average
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 2023–2024. Scores are compared across three years.*

v *Indicates an increase from review three years prior.*

~ *Indicates a decrease from review three years prior.*

Indicates no change from review three years prior.

The statewide average scores (based on the two MCOs) demonstrated no scores lower than 80% except Standard IX- Sub contractual Relationships and Delegation which shows an average of 50%, mainly due to there being only 4 elements in the standard. The Department has provided guidance and will continue to work with the plans on correcting those elements that were not met. The only other Standard not above 90% is Standard VI- Grievance and Appeals at an 87% average. The Department will continue guidance and corrective actions to improve that standard as we will for all scores not at 100%

Figure 11 displays the statewide average Compliance Monitoring results for the most recent year that each standard area was reviewed. FY 2019–2020 was the second year of RAE operations, no comparative statewide averages are available for the standards that will be reviewed in FY 2020–2021, the third year of compliance standard rotation for the RAEs.

Figure 11 Compliance with Regulations – Statewide Performance for the Seven RAEs

Standard and Applicable Review Years	Statewide Average
Standard I – Coverage and Authorization of Services (2022-2023)	92%
Standard II – Access and Availability (2022-2023)	96%
Standard III – Coordination and Continuity of Care (2021-2022)	97%
Standard IV – Member Rights and Protections (2021-2022)	100%
Standard V – Member Information (2021-2022)	89%
Standard VI – Grievance and Appeal Systems (2022-2023)	88%
Standard VII – Provider Participation and Program Integrity (2020-2021)	97%
Standard VIII – Credentialing and Recredentialing (2020-2021)	98%
Standard IX – Subcontracts and Delegation (2020-2021)	89%
Standard X – Quality Assessment and Performance Improvement (2020-2021)	100%
Standard XI – Early and Periodic Screening, Diagnostic, and Treatment Services (2022-2023)	100%

In the final year of the RAE contracts, the Department will review four standard areas (Standard III -Coordination and Continuity of Care, Standard IV- Member Rights, Protections, and Confidentiality, Standard VIII Credentialing and Recredentialing, Standard XI Early and Periodic Screening, Diagnostic, and Treatment Services). The statewide average score was over 90 percent compliant in eight of the eleven standards, indicating an understanding by the RAEs of the majority of federal regulations related to standards, and organizational processes are sufficient to implement those requirements. For Standard V – Member Information, Standard IX – Subcontracts and Delegation and Standard VI – Grievance and Appeal Systems scores indicate an opportunity to improve RAE understanding of federal and State requirements related to this content area.

Validation of Performance Measures

- Performance Measures are rates that are designed to indicate how well a health plan is providing care and services. The measures used in Colorado are the same measures used throughout the country.
- The purpose of validating the Performance Measures is to ensure the data collected and outcomes reported are accurate and valid.

The Department evaluated the RAEs' accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. For the current reporting period, Health Services Advisory Group (HSAG) determined that the data collected and reported for the Department-selected measures by all seven RAEs followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

The following Tables reflect FY 2023-24 for data from FY 2022–2023 (MY 2023). -20 performance measure results for the statewide average and the corresponding incentive performance targets for the RAEs. Cells shaded green indicate the statewide average's performance met or exceeded the FY 2022–2024 (MY 2023) performance goal (as determined by the Department). Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Figure 12 - MY 2023 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	55.76%	59.54%	52.20%	58.80%	50.58%	51.62%	56.05%	54.25%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	56.24%	51.08%	47.43%	69.57%	47.03%	60.81%	33.90%	50.24%
Follow-Up Within 7 Days of an ED Visit for SUD	37.88%	35.65%	28.16%	36.07%	29.46%	34.15%	32.15%	32.38%
Follow-Up After a Positive Depression Screen	67.16%	83.84%	43.33%	37.80%	49.28%	55.74%	59.70%	55.45%
Behavioral Health Screening or Assessment for Children in the Foster Care System	14.86%	14.38%	9.92%	36.59%	25.58%	13.25%	15.73%	17.44%

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

For performance measure validation, all RAEs had adequate processes in place regarding their eligibility and enrollment of members, how they processed claims and encounters, and how they integrated their data for the measures being calculated. Although the statewide average met none of the performance targets, all seven (100 percent) RAEs exceeded the statewide average for Engagement in Outpatient Substance Use Disorder (SUD) Treatment.

While there are no recommendations for improvement related to the RAEs' information systems (IS) standards review, there are opportunities for improvement in performance. Due to the statewide averages for the RAEs falling below the performance targets in all performance measures, the Department will further collaborate with the RAEs to identify interdependencies across the measures (e.g., access to timely outpatient services, etc.), in order to target a specific intervention for the next year that could positively impact rates for multiple measures. Furthermore, the Department is considering convening a forum in which the higher performing RAEs could share best practices while all RAEs collaborate on program wide solutions to common barriers. The Department supports these efforts by monitoring the

RAEs' progress through routine meetings and informal written updates as the Department determines to be most effective and appropriate

HEDIS measure Rates and Validation – MCO Capitation Initiative Information Systems Standards Review

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

Performance Measure Results

Figure 13 and Figure 14 display the Medicaid statewide weighted averages for HEDIS 2021 through HEDIS 2023, along with the percentile ranking for each HEDIS 2023 rate for the high- and low performing measure rates for the MCO capitation initiative health plans (Denver Health Medical Plan [DHMP] and Rocky Mountain Health Plans Medicaid Prime [RMHP Prime]). Statewide performance measure results for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2023 when available. Additionally, rates for HEDIS 2023 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for HEDIS 2020 shaded red with two carets (^^) indicate statistically significant decline in performance from the previous year.1-1

Statewide Strengths Related to HEDIS Rates and Validation

Figure 13 MCO Capitation Initiative Statewide Weighted Averages

Performance Measures	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2023 Percentile Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
52 to 64 Years[H]	41.29%	45.65%	51.48%^	—
65 to 74 Years[H]	34.32%	37.87%	44.10%^	—

Cervical Cancer Screening				
Cervical Cancer Screening[H]	40.67%	37.73%	43.64%^	10th–24th
Child and Adolescent Well-Care Visits[H]				
Total	41.16%	42.55%	46.05%^	25th–49th
Childhood Immunization Status				
Combination 3[H]	61.94%	72.47%	69.05%	75th–89th
Combination 7[H]	53.10%	59.64%	64.51%^	75th–89th
Combination 10[H]	40.25%	42.05%	44.33%	75th–89th
Chlamydia Screening in Women				
16 to 20 Years[H]	75.11%	76.08%	79.04%	≥90th
21 to 24 Years[H]	57.93%	62.14%	60.10%	25th–49th
Colorectal Cancer Screening				
46 to 50 Years[H]	—	15.09%	19.23%^	—
51 to 65 Years[H]	—	31.24%	34.45%^	—
66 to 75 Years[H]	—	34.20%	34.84%	—
Developmental Screening in the First Three Years of Life				
Totall[SA]	NA	60.78%	68.60%^	—
Immunizations for Adolescents				
Combination 1[H]	64.92%	71.89%	**63.00%^^**	<10th
Combination 2[H]	35.48%	36.69%	38.74%	50th–74th
Lead Screening in Children				
Lead Screening in Children[H]	—	61.16%	59.10%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total[H]	69.35%	67.47%	66.65%	10th–24th
Counseling for Nutrition—Total[H]	73.46%	72.44%	74.97%	50th–74th
Counseling for Physical Activity—Total[H]	72.54%	71.14%	74.13%	50th–74th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits[H]	54.34%	58.28%	58.62%	50th–74th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	54.39%	59.29%	64.19%^	25th–49th
Screening for Depression and Follow-Up Plan				
12 to 17 Years[SA]	7.69%	33.62%	31.80%	—
18 to 64 Years[SA]	7.28%	14.42%	16.63%	—
65 Years and Older[SA]	2.37%	5.15%	5.46%	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				

MMEC—15 to 20 Years[SA]	33.58%	21.05%	21.63%	—
MMEC—21 to 44 Years[SA]	20.17%	19.21%	19.35%	—
LARC—15 to 20 Years[SA]	6.51%	5.36%	5.84%	—
LARC—21 to 44 Years[SA]	4.87%	4.63%	4.63%	—
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days[SA]	0.00%	23.46%	25.66%	—
MMEC—21 to 44 Years—3 Days[SA]	5.77%	17.51%	14.91%	—
MMEC—15 to 20 Years—90 Days[SA]	34.78%	60.49%	61.06%	—
MMEC—21 to 44 Years—90 Days[SA]	40.74%	49.53%	46.32%	—
LARC—15 to 20 Years—3 Days[SA]	0.00%	6.17%	11.50%	—
LARC—21 to 44 Years—3 Days[SA]	0.00%	5.52%	4.47%	—
LARC—15 to 20 Years—90 Days[SA]	19.57%	28.40%	29.20%	—
LARC—21 to 44 Years—90 Days[SA]	16.56%	21.69%	19.86%	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—21 Years and Older[SA]	—	—	68.26%	—
Timeliness of Prenatal Care—Under 21 Years[SA]	—	—	71.74%	—
Postpartum Care—21 Years and Older[SA]	—	—	62.45%	—
Postpartum Care—Under 21 Years[SA]	—	—	72.83%	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years[H]	59.68%	57.14%	68.87%^	—
19 to 64 Years[H]	52.00%	55.70%	56.17%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years[H]	—	96.52%	95.20%	≥90th
18 to 64 Years[H]	—	54.17%	**60.09%^^**	≥90th
65 Years and Older[H]	—	NA	NA	—
Concurrent Use of Opioids and Benzodiazepines[*]				
18 to 64 Years[*,SA]	14.93%	8.17%	7.95%	—
65 Years and Older[*,SA]	19.29%	7.74%	8.43%	—
Controlling High Blood Pressure				
18 to 64 Years[H]	36.77%	35.12%	46.59%^	—
65 to 85 Years[H]	42.45%	43.93%	53.70%^	—
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18 to 64 Years[H]	—	39.73%	46.54%^	—
HbA1c Control (<8.0%)—65 to 75 Years[H]	—	47.79%	53.26%^	—
Poor HbA1c Control (>9.0%)—18 to 64 Years[*,H]	57.64%	52.03%	44.79%^	—
Poor HbA1c Control (>9.0%)—65 to 75 Years[*,H]	46.53%	42.40%	38.00%	—

HIV Viral Load Suppression				
18 to 64 Years[SA]	—	0.00%	52.27%^	—
65 Years and Older[SA]	NA	NA	68.09%	—
Use of Opioids at High Dosage in Persons Without Cancer[*]				
18 to 64 Years[*,SA]	4.11%	4.06%	3.50%	—
65 Years and Older[*,SA]	2.48%	5.07%	5.37%	—
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	53.83%	54.29%	55.49%	25th–49th
Antidepressant Medication Management				
Effective Acute Phase Treatment—18 to 64 Years[H]	60.87%	64.50%	66.97%	—
Effective Acute Phase Treatment—65 Years and Older[H]	74.36%	77.65%	81.13%	—
Effective Continuation Phase Treatment—18 to 64 Years[H]	41.07%	45.06%	46.28%	—
Effective Continuation Phase Treatment—65 Years and Older[H]	64.10%	49.41%	45.28%	—
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)[*]				
18 to 64 Years[*,H]	58.37%	55.26%	**47.50%^^**	—
65 to 75 Years[*,H]	NA	NA	55.00%	—
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]	79.50%	81.57%	83.27%	75th–89th
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years[H]	—	9.20%	11.70%	<10th
7-Day Follow-Up—18 to 64 Years[H]	26.47%	21.34%	24.77%	10th–24th
7-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years[H]	—	26.44%	32.98%	<10th
30-Day Follow-Up—18 to 64 Years[H]	36.30%	31.01%	37.29%^	10th–24th
30-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years[H]	—	17.65%	**4.35%^^**	<10th
7-Day Follow-Up—18 to 64 Years[H]	—	21.04%	19.51%	—
7-Day Follow-Up—65 Years and Older[H]	—	11.67%	13.51%	—
30-Day Follow-Up—13 to 17 Years[H]	—	23.53%	10.87%	<10th
30-Day Follow-Up—18 to 64 Years[H]	—	30.56%	30.43%	—

30-Day Follow-Up—65 Years and Older[H]	—	20.00%	21.62%	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6 to 17 Years[H]	NA	NA	NA	—
7-Day Follow-Up—18 to 64 Years[H]	33.98%	28.18%	24.40%	25th–49th
7-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years[H]	NA	NA	NA	—
30-Day Follow-Up—18 to 64 Years[H]	50.00%	46.14%	43.45%	10th–24th
30-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	31.87%	40.50%	40.94%	25th–49th
Continuation and Maintenance Phase[H]	NA	NA	45.45%	10th–24th
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—18 to 64 Years[H]	—	38.30%	40.57%	25th–49th
Initiation of SUD Treatment—Total—65 Years and Older[H]	—	51.64%	45.00%	50th–74th
Engagement of SUD Treatment—Total—18 to 64 Years[H]	—	9.59%	10.55%	25th–49th
Engagement of SUD Treatment—Total—65 Years and Older[H]	—	3.69%	2.69%	10th–24th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[H]	59.09%	58.49%	72.00%	≥90th
Cholesterol Testing—Total[H]	45.45%	43.40%	54.00%	≥90th
Blood Glucose and Cholesterol Testing—Total[H]	43.94%	41.51%	54.00%	≥90th
Screening for Depression and Follow-Up Plan				
12 to 17 Years[SA]	7.69%	33.62%	31.80%	—
18 to 64 Years[SA]	7.28%	14.42%	16.63%	—
65 Years and Older[SA]	2.37%	5.15%	5.46%	—
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[SA]	52.74%	60.90%	**53.89%^^**	—
Rate 2: Buprenorphine[SA]	31.66%	39.17%	**35.65%^^**	—
Rate 3: Oral Naltrexone[SA]	4.13%	3.62%	3.45%	—
Rate 4: Long-Acting, Injectable Naltrexone[SA]	0.72%	1.09%	0.89%	—
Rate 5: Methadone[SA]	20.54%	22.74%	**17.63%^^**	—
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years[SA]	22.66	26.64	26.12	—

Plan All-Cause Readmissions				
Observed Rate[H]	8.85%	8.92%	9.79%	—
Expected Rate[H]	9.71%	9.64%	9.87%	—
O/E Ratio[H]	0.9107	0.9246	0.9916	25th–49th
Outlier Rate[H]	—	43.25	45.09	—
PQI 01: Diabetes Short-Term Complications Admission Rate[*]				
18 to 64 Years[*,SA]	27.29	14.55	12.26	—
65 Years and Older[*,SA]	18.41	3.58	5.60	—
PQI 05: COPD or Asthma in Older Adults Admission Rate[*]				
40 to 64 Years[*,SA]	258.84	15.27	11.91	—
65 Years and Older[*,SA]	1,210.72	36.96	29.14	—
PQI 08: Heart Failure Admission Rate[*]				
18 to 64 Years[*,SA]	76.05	16.02	16.74	—
65 Years and Older[*,SA]	1,033.38	236.22	146.31	—
PQI 15: Asthma in Younger Adults Admission Rate[*]				
18 to 39 Years[*,SA]	6.65	3.10	1.90	—

** 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 that the denominator was too small to report the rate or 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.

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

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

Medical Loss Ratios

The Department evaluates Medical Loss Ratio's (MLR) for its managed care entities Rocky Mountain Health Plan (RMHP) and Denver Health Medical Plan(DHMP) based on the percent of premium used to pay for medical claims and activities that improve the quality of care; a basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to Health First Colorado Medicaid members. While annual contract requirements align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year, performance measurement aligns with a calendar year. Performance goals for each measure are based on a 2 year look back. For example, the performance goals for 2024 are based on data from calendar year 2022. Target goals in relation to performance are reflected in Figure 15.

Figure 15

Rocky Mountain Health Plan

Measure	2022 Performance	2023 Goal	2023 Performance	2024 Goal	2024 Performance
Diabetes Poor Control <9%	29.51%	67.1%	18.26%	29.45%	TBD
Timeliness of Prenatal Care and Postpartum Care	Prenatal Care: 93.70% Postpartum care: 84.81%	Prenatal Care: 60.1% Postpartum Care: 37%	Prenatal Care: 90.83% Postpartum Care: 90.39%	Prenatal Care: 93.70% Postpartum Care: 84.83%	TBD
Depression Screening & Follow-up	65.38%	N/A	63.7%	67.84%	TBD
Initiation and Engagement of Substance Use Disorder Treatment	Initiation: 55.10% Engagement: 12%	Initiation: 30.5% Engagement: 9.1%	Initiation: 59.60% Engagement: 16.80%	Initiation: 55.10% Engagement: 12%	TBD

Denver Health Medical Plan

Measure	2022 Performance	2023 Goal	2023 Performance	2024 Goal	2024 Performance
Initiation and Engagement of Substance Use Disorder Treatment	Initiation: 42.06% Engagement: 7.07%	Initiation: 43.5% Engagement: 7.9%	Initiation: 47.71% Engagement: N/A	Initiation: 43.65% Engagement: 11.06%	Initiation: TBD Engagement: TBD
Well Visits for Children 0-15 Months Well visits for Children 15-30 Months Well Visits for Children 3-21 Years	0-15 Months: 58.28% 15-30 Months: 59.29% 3-21 Years: 42.9%	0-15 Months: 57% 15-30 Months: 59.4% 3-21 Years: 43.4%	0-15 Months: 58.62% 15-30 Months: 64.19 % 3-21 Years: 46.56%	0-15 Months: 59.25% 15-30 Months: 61.16% 3-21 Years: 44.71%	0-15 Months: TBD 15-30 Months: TBD 3-21 Years: TBD
Depression Screening & Follow-up	12.16%	N/A	19.92%	19.94%	TBD
Timeliness of Prenatal and Postpartum Care	Prenatal Care: 80.78% Postpartum Care: 76.64%	Prenatal Care: 84.1% Postpartum Care: 69.7%	Prenatal Care: 86.37% Postpartum Care: 82.48%	Prenatal Care: 81.80% Postpartum Care: 77.48%	TBD

The Department continues to work with RMHP and DHMC in implementing a rapid-cycle improvement plan for driving systematic and continuous improvement for Diabetes Poor Control <9%, Depression Screening & Follow-up, and Patient Activation, and Childhood Immunization in order to achieve the defined performance goals.

Encounter Data Validation

The RAE 411 overread evaluated each RAE's compliance with the Department's BH encounter data submission standards, as well as the consistency and accuracy with which each RAE uses Medical Record Reviews to validate its BH Encounter data. The Department's over-read evaluated whether the RAEs' internal validation results were consistent with Colorado's USCS manuals specific to the study period. The Department entered all overread results into a standardized data collection tool that aligned with the Department's Annual RAE BH Encounter Data Quality Review Guidelines. The Department tabulated the over-read results

by service category to determine the percentage of overread cases and encounter data elements for which the Department agreed with the RAEs' Encounter Data Validation (EDV) responses.

The table below presents the RAEs' aggregated (which includes DHMP's 411 results) self-reported BH encounter data service coding accuracy results by BH service category and validated data element

FY 2023–2024 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%	98.4%
Diagnosis Code	89.0%	92.1%	94.1%
Place of Service	NA	73.8%	97.1%
Service Category Modifier	NA	88.4%	97.9%
Units	NA	95.3%	97.4%
Revenue Code	90.9%	NA	NA
Discharge Status	92.7%	NA	NA
Service Start Date	94.5%	95.9%	98.2%
Service End Date	73.0%	95.9%	98.3%
Population	NA	96.1%	98.5%
Duration	NA	92.8%	98.3%
Staff Requirement	NA	90.9%	97.4%

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

Table 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

FY 2023–2024 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	97.5%	97.5%
Diagnosis Code	98.8%	100.0%	98.8%

Data Element	Inpatient Services (80 Over-Read Cases)	Psychotherapy Services (80 Over-Read Cases)	Residential Services (80 Over-Read Cases)
Place of Service	NA	96.3%	97.5%
Service Category Modifier	NA	96.3%	96.3%
Units	NA	98.8%	97.5%
Revenue Code	98.8%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	98.8%	97.5%
Service End Date	100.0%	98.8%	97.5%
Population	NA	100.0%	98.8%
Duration	NA	98.8%	97.5%
Staff Requirement	NA	95.0%	97.5%

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

FY 2023–2024 is the fifth 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.

MCO 412 Self-Reported EDV Results

The MCO 412 audit overread evaluated each MCO's compliance with the Department's encounter data submission standards, as well as the consistency and accuracy with which each MCO uses MRR to validate its encounter data. The Department's overread evaluated whether the MCOs' internal validation results were accurate based on the review of the encounter data and corresponding medical record documentation. The Department entered all overread results into a standardized data collection tool that aligned with the Department's Annual MCO Encounter Data Quality Review Guidelines. The Department tabulated the overread results by service category to determine the percentage of overread cases and encounter data elements for which HSAG agreed with the MCOs' EDV responses.

The below table presents the MCOs' self-reported encounter data service coding accuracy results, aggregated for both MCOs by service category and validated data element.

FY 2023–2024 MCOs' Aggregated, Self-Reported EDV Results by Data Element and Service Category*

Data Element	Inpatient	Outpatient	Professional	FQHC	Aggregate Results
Date of Service	91.7%	86.4%	83.5%	98.1%	89.9%
Through Date	91.7%	NA	NA	NA	91.7%
Diagnosis Code	88.8%	82.0%	74.8%	77.2%	80.7%
Surgical Procedure Code	93.2%	NA	NA	NA	93.2%
Procedure Code	NA	84.5%	71.8%	91.3%	82.5%
Procedure Code Modifier	NA	86.4%	84.0%	94.2%	88.2%
Discharge Status	89.3%	NA	NA	NA	89.3%
Units	NA	82.5%	85.9%	97.1%	88.5%

** 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.

The table below 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.

MCO 412 FY 2023–2024 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	97.5%	240	99.6%
Outpatient	40	100%	200	100%
Professional	40	100%	200	100%
FQHC	40	100%	200	100%
Total	**160**	**99.4%**	**840**	**99.9%**

Overall, results from HSAG's FY 2023–2024 MCO 412 EDV over-read showed that 159 out of 160 cases had complete case-level agreement with the MCOs' internal validation, resulting in a 99.4 percent complete case-level agreement. Additionally, HSAG agreed with 99.9 percent of the MCOs' internal validation results for the total number of individual data elements reviewed.

EPSDT Participation Report (form CMS-416)

The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services. The Form CMS-416 is used by CMS to collect basic information from the Department on the States Medicaid and CHIP programs to assess the effectiveness of EPSDT. Annually the Department must provide CMS with information related to 1) Number of children provided child health screening service, 2) Number of children participating in Services, 3 Number of children referred for corrective treatment, 4) number of children receiving dental services, and 5) Lead Testing Form 416 provides CMS our Department Results in attaining goals set. This link is provided to learn more about the Department's EPSDT Participation Report.

- Note: The Annual CMS 416 Report is due to CMS April 1st of each year at which point the Department will provide an evaluation and effectiveness review for EPSDT.

Validation of Performance Improvement Projects

During FY 2023–2024, the RAEs and MCOs, CHP+MCOs, and the CHP+ PAHP (MCEs, collectively) initiated new clinical and nonclinical PIPs. The MCEs' clinical PIP topics varied and were selected by the MCEs from a list of approved topics identified by the Department. The MCEs' nonclinical PIPs focused on one topic selected by the Department, which focused on increasing the percentage of members screened for social determinants of health (SDOH). The MCEs reported the PIP designs and baseline results for the FY 2023–2024 validation. For FY 2023–2024, HSAG evaluated each MCE's PIP for adherence to acceptable PIP methodology and assigned a validation rating. All MCEs received a validation rating of High Confidence for this year's validation of the clinical and nonclinical PIPs. DentaQuest, also received High Confidence for the clinical PIP The PIPs had not progressed to being evaluated for the second validation rating, which evaluates achieving significant improvement; therefore, the second validation rating was Not Assessed for all PIPs. In FY 2024–2025, when the MCEs report Remeasurement 1 results, the PIPs will be evaluated and assigned a confidence level for both validation ratings.

Based on the FY 2023–2024 PIP validation activities, HSAG did not identify any statewide opportunities for improvement for all of the MCEs except for DentaQuest. The opportunities for improvement specific to DentaQuest's nonclinical PIP were to clearly demonstrate that accurate, reliable, and meaningful data could be produced for monitoring improvement in indicator results for the duration of this project.

Figure 16 displays the FY 2023-2024 statewide PIP results for all the MCEs.

Figure 16 Statewide PIP Results

Plan Name and Plan Type	PIP Topic	Type of PIP	Indicator Description	Validation Rating 1: Confidence in Adherence to Acceptable Methodology for All Phases of the PIP		
				Percent of All Elements *Met*	Percent of Critical Elements *Met*	Confidence Level
Colorado Access **CHP+**	Social Determinants of Health Screening	Non clinical	The percentage of CHP+ MCO members who were screened for SDOH using the Core 5 SDOH screening tool.	100%	100%	*High Confidence*
	Child and Adolescent Well-Care Visits	Clinical	The percentage of CHP+ MCO members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care physician or an obstetrician/ gynecologist practitioner during the measurement year.	100%	100%	*High Confidence*
RAE 3 - Colorado Access **RAE**	Social Determinants of Health Screening	Non clinical	The percentage of Region 3 members who were screened for SDOH using the Core 5 SDOH screening tool.	100%	100%	*High Confidence*
	Follow-Up After Hospitalization for Mental Illness	Clinical	The percentage of discharges for Region 3 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health	100%	100%	*High Confidence*

			provider within seven days after discharge.			
RAE 5 - Colorado Access **RAE**	Social Determinants of Health Screening	Non clinical	The percentage of Region 5 members who were screened for SDOH using the Core 5 SDOH screening tool.	100%	100%	*High Confidence*
	Follow-Up After Hospitalization for Mental Illness	Clinical	The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	100%	100%	*High Confidence*
Denver Health Medical Plan **CHP+**	Improving Social Determinants of Health Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services	Non clinical	The percentage of DHMP CHP+ members who were empaneled at Denver Health, had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least one HRSN flowsheet question) completed in the past year.	100%	100%	*High Confidence*
	Improving Well-Care Visit Rates for Child and Adolescent DHMP CHP+ Members	Clinical	The percentage of CHP+ members ages 3–21 years who had at least one comprehensive WCV with a primary care provider or an obstetrician/gynecologist practitioner	100%	100%	*High Confidence*

			during the measurement period.			
Denver Health Medical Plan **MCO**	Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services	Non clinical	The percentage of DHMP Medicaid members who were empaneled at Denver Health, had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least HRSN flowsheet question) completed in the past year.	100%	100%	*High Confidence*
	Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members	Clinical	The percentage of DHMP Medicaid members ages 3–21 years who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement period.	100%	100%	*High Confidence*
Kaiser Permanente **CHP+**	Social Determinants of Health Screening	Non clinical	The percentage of CHP+ members with a complete SDOH questionnaire.	100%	100%	*High Confidence*
	Well-Child Visits	Clinical	The percentage of eligible CHP+ members who receive six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday (if age <15 months), or two or more visits on or before the 30-month	100%	100%	*High Confidence*

			birthday (if ages 15–30 months).			
RAE 1 - Rocky Mountain Health Plan **RAE**	Improving the rate of Social Determinants of Health Screening for RAE Members in Region 1	Non clinical	The percentage of eligible members in the Accountable Care Collaborative Program who had at least one billed encounter and who completed an SDOH screening in the measurement year.	100%	100%	*High Confidence*
	Follow-Up After Hospitalization for Mental Illness 7-Day and 30-Day in RAE Behavioral Health Members	Clinical	The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge. The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 30 days after discharge.	100%	100%	*High Confidence*
Rocky Mountain Health Plans **CHP+**	Improving the Rate of Social Determinants of Health Screening for CHP+ Members	Non clinical	The percentage of eligible CHP+ members who had at least one billed encounter in the measurement year and who completed an SDOH screening.	100%	100%	*High Confidence*

	Well-Child Visit Rates for RMHP CHP+ Members	Clinical	The percentage of eligible CHP+ members ages 3 to 21 years who completed one or more well-care visits during the measurement year.	100%	100%	*High Confidence*
Rocky Mountain Health Plans Prime **MCO**	Improving the Rate of Social Determinants of Health Screening for PRIME Members	Non clinical	The percentage of eligible RMHP Prime members who had at least one billed encounter in the measurement year and who completed an SDOH screening.	100%	100%	*High Confidence*
	Diabetes A1c Poor Control for Prime MCE Managed Care Entity Members	Clinical	The percentage of eligible RMHP Prime members ages 18–75 years with a diagnosis of diabetes whose most recent HbA1c level was greater than 9.0%, had a test with a missing result, or had no HbA1c test completed during the measurement year.	100%	100%	*High Confidence*
RAE 2 - Northeast Health Partners **RAE**	Screening for Social Determinants of Health	Non clinical	The percentage of members with at least one behavioral health visit who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	100%	100%	*High Confidence*
	Follow -Up After Emergency Department Visits for Substance Use: Ages 13 and Older	Clinical	The percentage of emergency department visits for members ages 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days	100%	100%	*High Confidence*

			of an emergency department visit.			
RAE 4 - Health Colorado, Inc. **RAE**	Social Determinants of Health Screening	Non clinical	The percentage of members with at least one behavioral health service who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	100%	100%	*High Confidence*
	Follow-Up After Emergency Department Visit for Substance Use	Clinical	The percentage of emergency department visits for members ages 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.	100%	100%	*High Confidence*
RAE 6 - Colorado Community Health Alliance **RAE**	Social Determinants of Health Screening	Non clinical	The percentage of new BHTOC and STOC cases for members attributed to Region 6 wherein the member was screened for unmet food, housing, utility, and transportation needs.	100%	100%	*High Confidence*
	Follow-Up After Hospitalization for Mental Illness	Clinical	The percentage of discharges for CCHA R6 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	100%	100%	*High Confidence*

RAE 7 - Colorado Community Health Alliance **RAE**	Social Determinants of Health Screening	Non clinical	The percentage of new BHTOC and STOC cases for members attributed to Region 7 wherein the member was screened for unmet food, housing, utility, and transportation needs.	100%	100%	*High Confidence*
	Follow-Up After Hospitalization for Mental Illness	Clinical	The percentage of discharges for CCHA R7 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	100%	100%	*High Confidence*
DentaQuest **PAHP**	Social Determinants of Health Screening – Member Survey	Non clinical	The percentage of enrollees who completed the SDOH member survey during the measurement period.	85%	88%	*Low Confidence*
	Increasing the Rate of Enrollees Accessing Preventative Dental Services - Oral Evaluations	Clinical	The percentage of eligible enrollees under age 21 years that received at least one oral evaluation dental service during the measurement year.	100%	100%	*High Confidence*

Percentage Score of Evaluation Elements *Met*—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Annual Quality Improvement Plans

The Department's Quality Strategy is designed for overseeing, creating and administering activities related to the Department's quality initiatives associated with improved health outcomes for our Health First Colorado Medicaid members, contract deliverables, and better healthcare delivery. As part of this strategy the Department works in collaboration with our EQRO and our RAE's in detailing the progress and effectiveness of each component of their Quality Improvement Plans. Each RAE develops a plan to provide a formal ongoing process by which the Department and the RAEs' utilize objective measures to monitor and evaluate the quality of services provided. Evaluation is often an annual evaluation of the prior year's quality improvement activities which includes recommendations for the following year. This link is provided here to review the RAE Quality plans with defined priorities are located at:

https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-deliverables

Validation of Network Adequacy

As required in 42 CFR §438.350(a), states which contract with MCOs must have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to beneficiaries across the continuum of services. The Department contracted with HSAG as its EQRO to conduct NAV analyses of the Medicaid and CHP+ healthcare practitioner, practice group, and entity networks for all MCEs.

Beginning in FY 2018–2019, the Department collaborated with its contracted EQRO to develop and maintain quarterly network adequacy reporting materials and instructional requirement documents, with the goal of standardizing the health plans' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the health plans' network adequacy results.

HSAG worked with the Department to identify applicable quantitative network adequacy standards by provider and plan type to be validated. Information such as description of network adequacy data and documentation, information flow from MCEs to the State and additional supporting information relevant to network adequacy monitoring and validation were obtained from the State and incorporated into all planning phases of validation activities.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.

The following table presents the network domains applicable to MCOs and RAEs; within each domain, network categories included in the NAV analyses were limited to categories corresponding to the health plans' minimum time and distance network requirements.

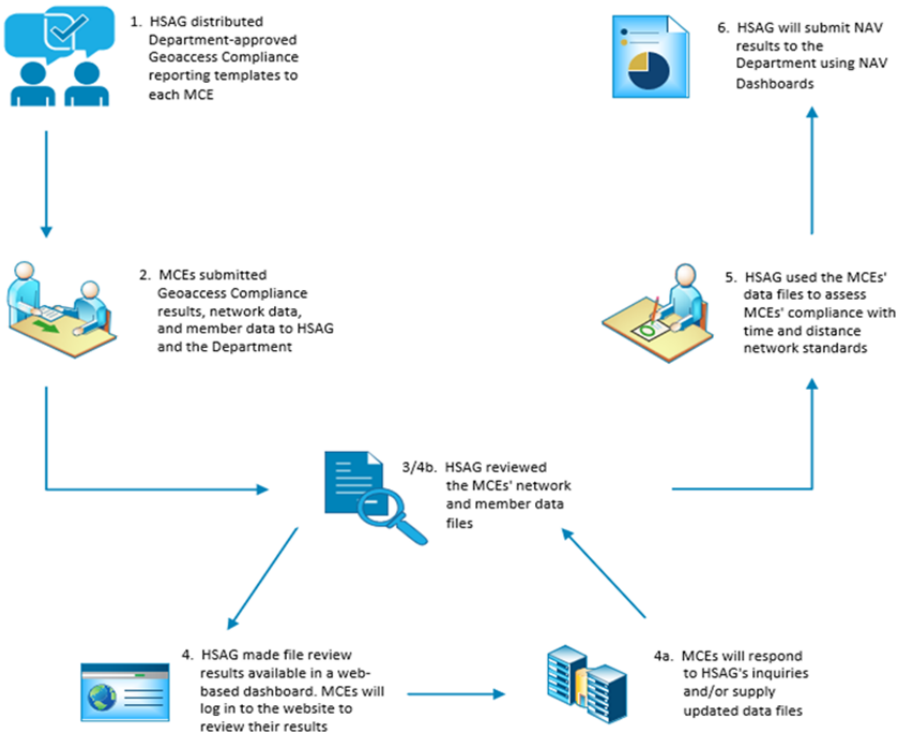
Provider Categories by MCE Type

Network Category	CHP+ MCOs	Medicaid MCOs	PAHP	RAE
Primary Care, Prenatal Care, and Women's Health Services[1]	X	X		X
Physical Health Specialists	X	X		
Behavioral Health	X	X		X
Facilities (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X		X
Dental Services (*Primary Care and Specialty Services*)			X	

Consistent with the Department's instructions to the health plans, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.

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

Figure X-X Quarterly NAV Data Processing and Validation Tasks



Concurrent with requesting the health plans' network and member data, HSAG requests Medicaid member files from the Department using a detailed member data requirements document for members actively enrolled with a health plan as of the last business day of each quarterly measurement period.

The EQRO utilizes the Department's member data to assess the completeness of the health plans' member data submissions (e.g., comparing the number of members by county between the two data sources).

MCEs Participating in the FY 2023-2024 NAV

CHP+ Managed Care Organizations (MCOs)

- Colorado Access CHP+ (COA CHP+)
- Denver Health Medical Plan CHP+ (DHMP CHP+)
- Kaiser Permanente (Kaiser)
- Rocky Mountain Health Plans CHP+ (RMHP CHP+)

Limited Managed Care Capitated Initiative Plans (Medicaid MCOs)

- Denver Health Medical Plan MCO (DHMP)
- Rocky Mountain Health Plans Prime (RMHP Prime)

CHP+ Prepaid Ambulatory Health Plan (PAHP)

- DentaQuest

Regional Accountable Entities (RAEs)

- RAE 1: Rocky Mountain Health Plans (RMHP)
- RAE 2: Northeast Health Partners (NHP)
- RAE 4: Health Colorado, Inc. (HCI)
- RAEs 3 and 5: Colorado Access (COA Region 3, COA Region 5)
- RAEs 6 and 7: Colorado Community Health Alliance (CCHA Region 6, CCHA Region 7)

Since implementation of NAV protocols, each state fiscal year HSAG validates the MCEs' self-reported compliance with minimum network requirements and provides the Department with both MCE-specific initial file review results in the NADIV dashboards and final validation results in quarterly NAV dashboards.

Additionally, pursuant to network capacity requirements under 42 CFR § 438.207(a) member to provider ratio metric standards were included in the NAV activities.

In accordance with the Balanced Budget Act of 1997, Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR 438.358 was aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The report of results must also contain an assessment of the strengths and weaknesses of the plans with regard to health care quality, timeliness, and access, make recommendations for improvement, and assess the degree to which any previous recommendations were addressed by the MCOs and PIHPs. Detailed listing of all metric standards by MCE type included in their respective contracts may be found in the Colorado Medicaid Annual Technical Reports web page, that includes methodology and activities.

In the following MCE sections, that may also be found in the Network Adequacy Validation report which is published annually and publicly posted on the Departments website, are the EQRO findings and selected results. HSAG further provides detailed assessment of each CHP+ MCO plans' strengths and opportunities for improvement and recommendations. Additional details may be accessed in the CO 2023-24 NAV Annual Report.

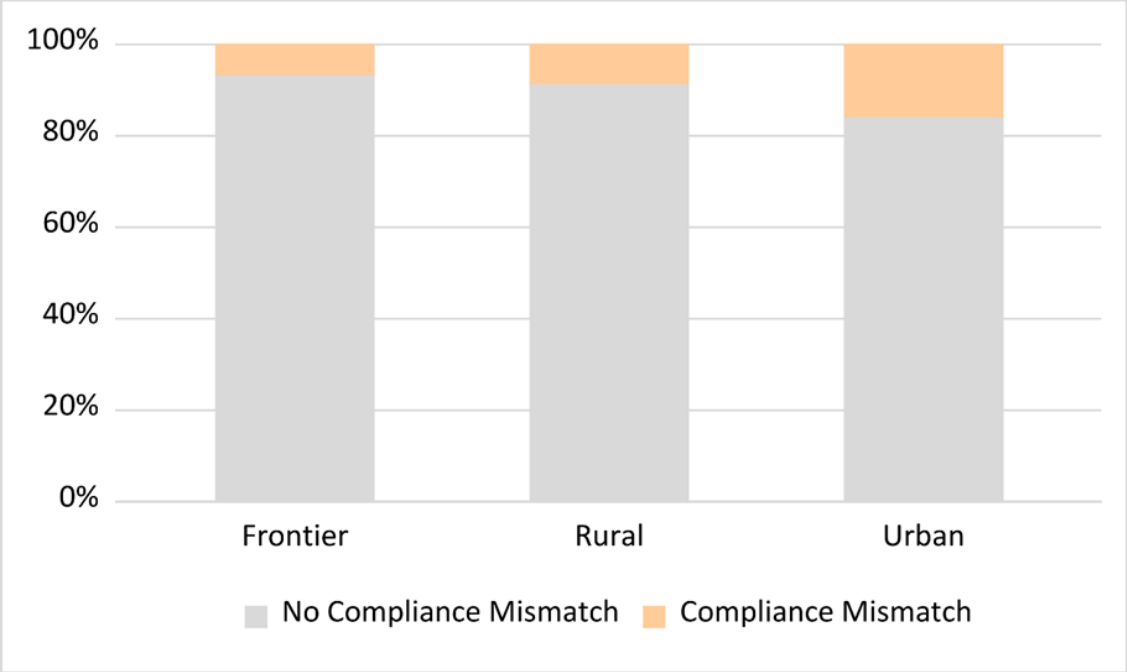
In the following sections the data-related findings in this report align with HSAG's validation of the MCEs' FY 2023–2024 Q2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2023, through December 31, 2023.

CHP+ Managed Care Organizations (MCOs)

This section summarizes the FY 2023–2024 NAV findings specific to the CHP+ (MCOs).

Figure 4-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all CHP+ MCOs by urbanicity.

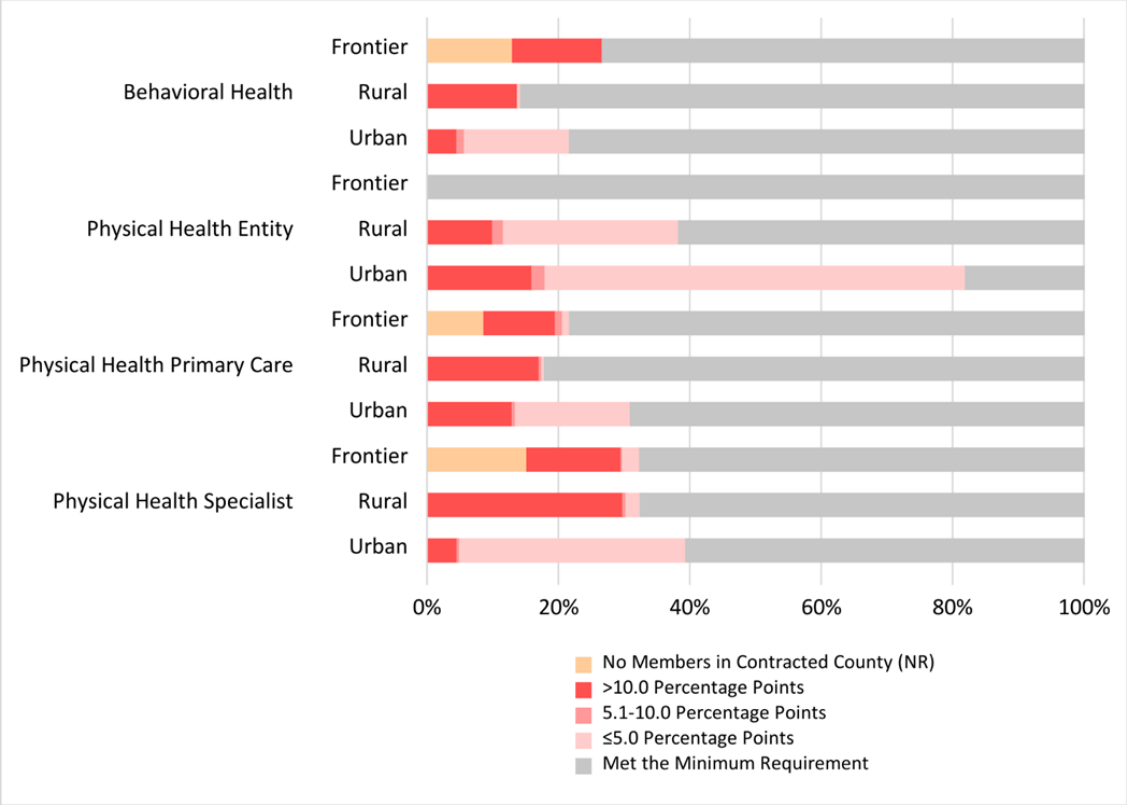
Figure 4-1—Aggregate CHP+ MCO Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 93.5 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 91.5 percent of reported results for rural counties, and 84.3 percent of reported results for urban counties.

Figure 4-2 displays the percentage of behavioral health and physical health primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2023-2024 Q2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance behavioral health and physical health primary care network requirements for the selected counties.[4-1]

Figure 4-2—Percentage of Aggregate CHP+ MCO Behavioral Health and Physical Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023

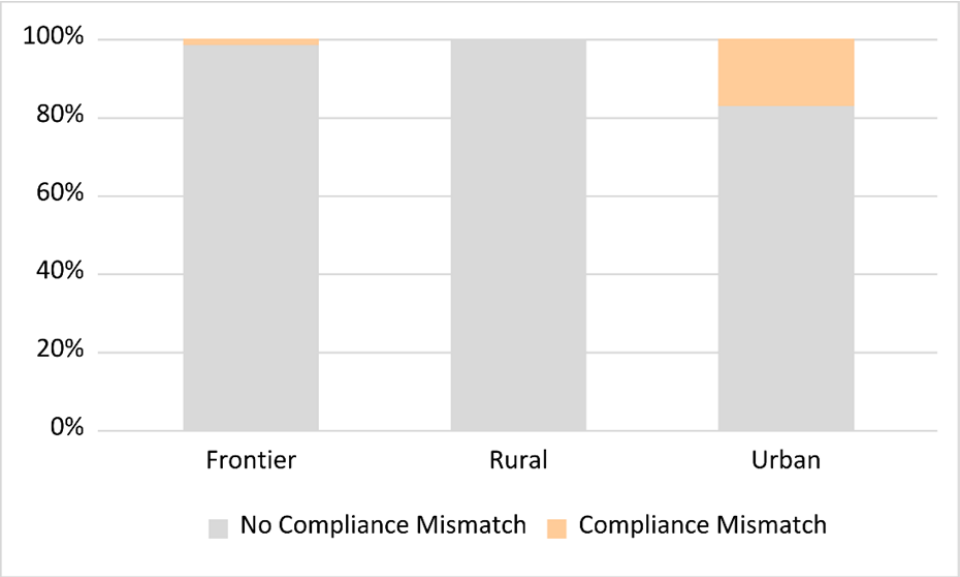


Medicaid Managed Care Organizations (MCOs)

This section summarizes the FY 2023–2024 NAV findings specific to the Managed Care Organizations (MCOs).

Figure 4-3 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all Medicaid MCOs by urbanicity.

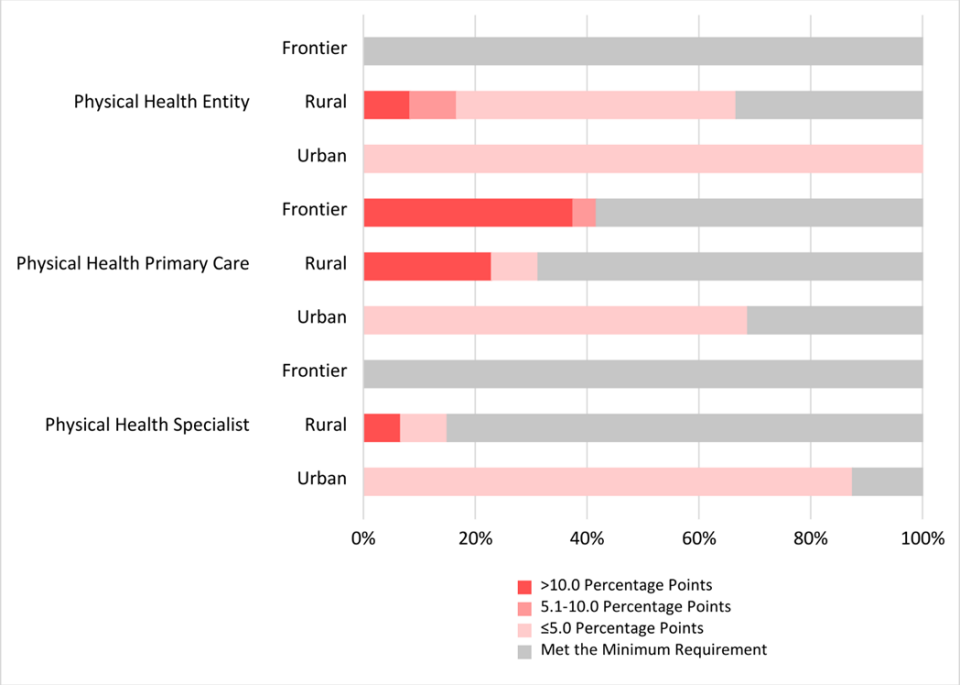
Figure 4-3—Aggregate Medicaid MCO Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 98.9 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 100 percent of reported results for rural counties, and 83.3 percent of reported results for urban counties.

Figure 4-4 displays the percentage of physical health primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for Medicaid MCO members by urbanicity for FY 2023–2024 Q2.

Figure 4-4—Percentage of Aggregate Medicaid MCO Physical Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023

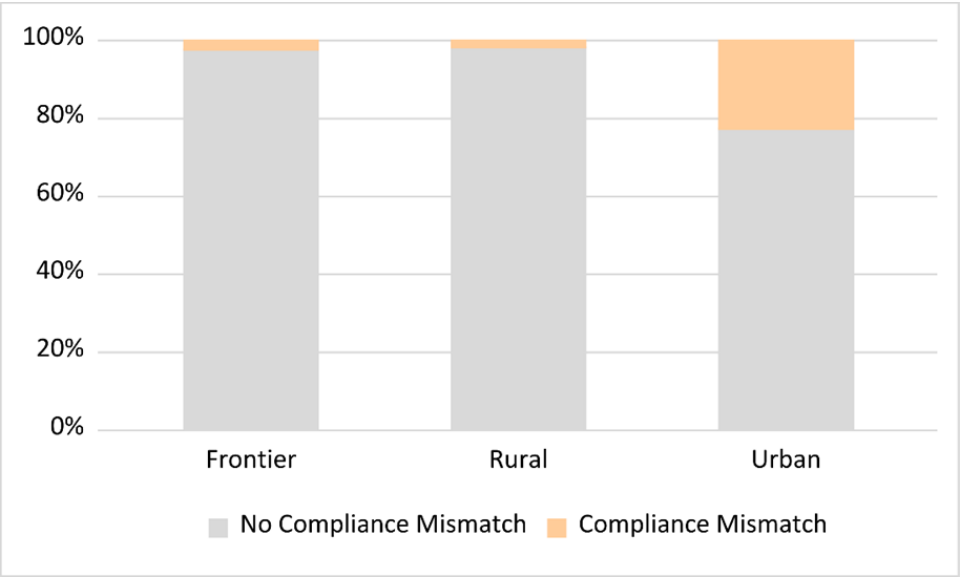


Regional Accountable Entities (RAEs)

This section summarizes the FY 2023–2024 NAV findings specific to the Regional Accountable Entities (RAEs).

Figure 4-7 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all RAEs by urbanicity.

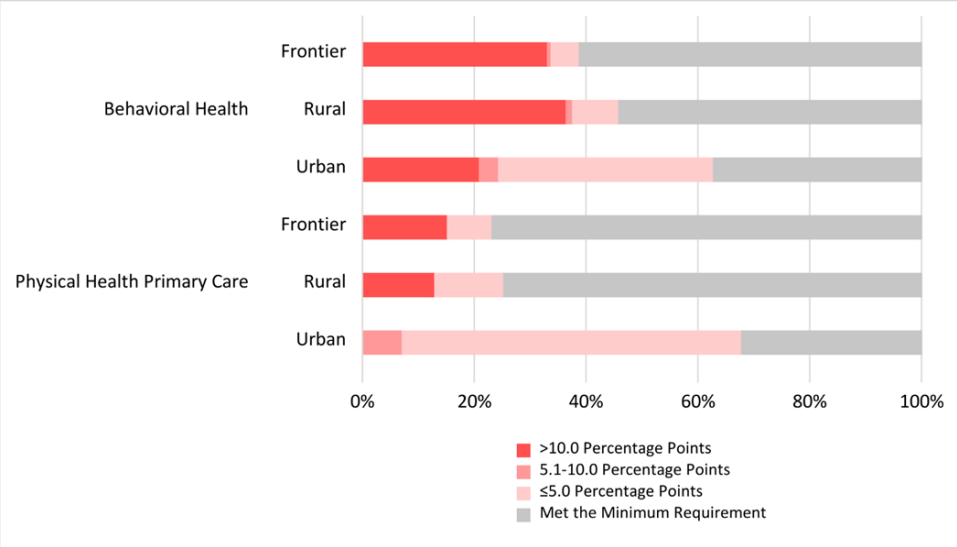
Figure 4-7—Aggregate RAE Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 97.7 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 98.2 percent of reported results for rural counties, and 77.4 percent of reported results for urban counties.

Figure 4-8 displays the percentage of behavioral health and physical health primary care results having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of RAE members with access in the network requirement by urbanicity for FY 2023–2024 Q2.

Figure 4-8—Percentage of Aggregate RAE Behavioral Health and Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023

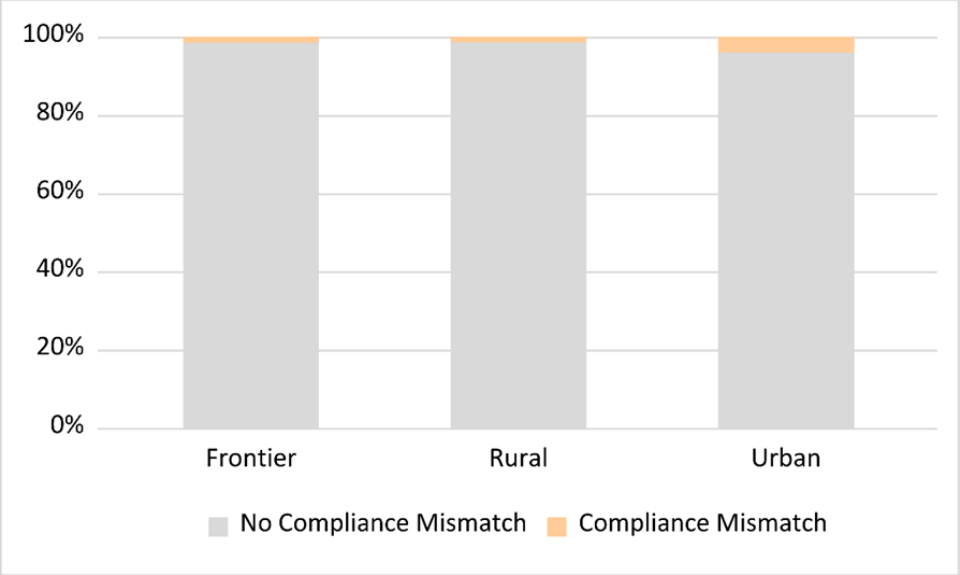


Dental Prepaid Ambulatory Health Plan (PAHP)

This section summarizes the FY 2023–2024 NAV findings specific to the Dental Prepaid Ambulatory Health Plan (PAHP)

Figure 4-5 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCE's quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCE's quarterly geoaccess compliance results) for the PAHP by urbanicity.

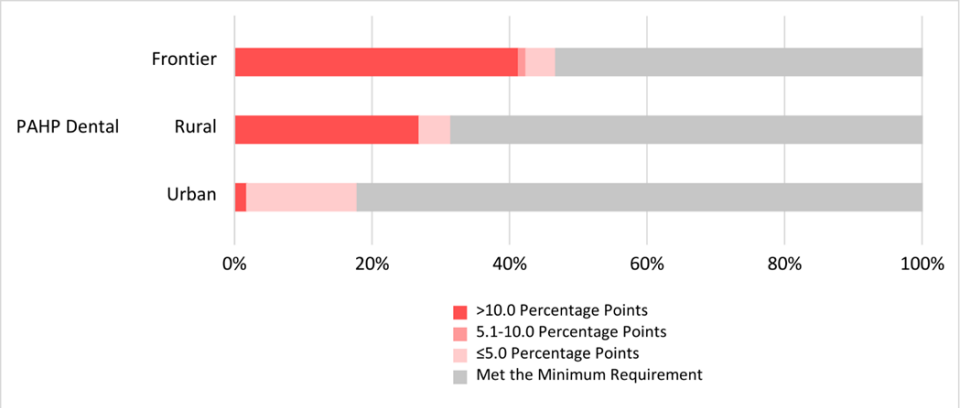
Figure 4-5—Aggregate PAHP Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 98.9 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 99.1 percent of reported results for rural counties, and 96.4 percent of reported results for urban counties.

Figure 4-6 displays the percentage of dental network results having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of PAHP members with access in the network requirement by urbanicity for FY 2023–2024 Q2.

Figure 4-6—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



NAV Dashboards

Following an analytic review of submitted quarterly data files from the health plans, HSAG provides the Department with the initial data quality assessment results in the NADIV dashboard tool. The NADIV dashboards reflect HSAG's review of the MCEs' most recent

quarterly network adequacy data submissions, including any potential findings warranting an MCE's data resubmission or clarification.

- The *Metric Results Overview* dashboard reflects the MCEs' member and practitioner data quality metric results for the data files each MCE submitted for quarterly NAV analysis. The dashboard displays file details of submitted data and any actions that may be required from the MCEs, as well as individual metric results.
- The *Network Category and Taxonomy Distribution* dashboard details the network category and taxonomy distributions of the practitioner and entity data submitted to HSAG by the MCEs for quarterly NAV analysis.
- The *Data Download—Metric Results* dashboard includes metric results for all submitted data and allows each MCE and the Department to filter and download specific metric result datasets.

Upon completion of each quarterly time and distance calculations and comparing the compliance results to the MCEs' self-reported geoaccess compliance results, HSAG provides the Department with the results in the NAV dashboards. The NAV dashboards, described below, included a comparison of the MCEs' self-reported NAV results and HSAG's calculated NAV results.

- The *Network Adequacy Assessment Comparison—Time and Distance* dashboard assessed the differences between the time and distance results submitted by the MCEs and the time and distance results calculated by HSAG. Each dashboard included a table and a map. The table for this dashboard could be filtered by MCE type, MCE name, urbanicity, county, network category, and compliance mismatch; the map for this dashboard could be filtered by MCE type, MCE name, and network category.
- The *Time and Distance Network Standards Assessment* dashboard assessed MCE compliance with the minimum network requirements by MCE, county, urbanicity, and network category, based on the time and distance results calculated by HSAG. The table for this dashboard could be filtered by MCE type, MCE name, urbanicity, county, network category, and compliance result; the map could be filtered by MCE type, MCE name, and network category.
- The *Time and Distance Standards Assessment—Trending* dashboard assessed MCE compliance with minimum network requirements compared to the previous quarter by MCE, county, urbanicity, and network category.

The *Time and Distance Standards Assessment—Results Brief Download* dashboard replaced the MCE-specific Results Briefs provided to the Department with a downloadable dataset detailing a list of the instances in which each MCE reported in its MS Excel geoaccess spreadsheet that it failed to meet a network requirement or HSAG calculated a failure to meet a network requirement based on the MCE's submitted data.

Network Changes and Deficiencies

The Department requested that its EQRO, HSAG, incorporate an overview of network changes and deficiencies reported in FY 2023–2024 into the annual report. As a part of the quarterly NAV data collection process, the MCEs are responsible for reporting all changes or deficiencies in their networks related to access to care within five business days of the change in writing to the Department.

During FY 2023–2024, two of the seven RAEs reported that they had experienced a network change or deficiency. Both RAE 2 and RAE 4 reported a termination of contract with the Chanda Center for Health and the Nuleaf Counseling Center in July 2023, impacting the Medicaid population seeking behavioral health services. Both RAEs reported minimum impact on access to care, citing no current utilization history requiring members to be transitioned from services.

On July 27, 2023, RAE 2 reported the termination of contract with GEO Reentry Services LLC, as well as issued a correction for reporting on Turning Point, a provider previously reported as having left the RAE 2 Medicaid network. Both the termination and correction affected RAE 2's population seeking behavioral health services. Additionally, on November 7, 2023, RAE 2 reported a change in hours of operation for the Centennial Mental Health Center's Journey Point Respite Program from 24 hours per day to 12 hours per day, which reduced the availability of 24-hour behavioral health services for the RAE's population.

On June 12, 2023, RAE 4 reported the termination of contract with primary care medical provider (PCMP) Affordable Health Clinic as ownership transitioned to Omnicare Health Solutions. RAE 4 reported that while Omnicare Health Solutions has retained the same providers and continues to serve existing members, it is not prepared to contract as a PCMP with RAE 4. On December 19, 2023, RAE 4 reported the termination of one PCMP provider in Pueblo County and one PCMP provider in Conejos County, impacting RAE 4 members seeking primary care services. RAE 4 does not anticipate disruption of services to members and will continue to monitor and assist with transition of care.

Table 4-26 presents a brief chronological overview of the MCE network change and deficiency materials, submitted to the Department per contractual requirements. Full materials detail the extent to which the MCE's network has been impacted by the closure or termination, as well as any and all steps the RAEs have taken to ensure access to care for the affected populations under Medicaid.

Table 4-26—Network Changes and Deficiencies Reported in FY 2023–2024

MCE	Submission Date	Network Change or Deficiency Identified
RAE 2	07/25/23	Termination of contract with the Chanda Center for Health, affecting NHP RAE 2's population seeking behavioral health services.

		Termination of contract with Nuleaf Counseling Center, affecting NHP RAE 2's population seeking behavioral health services.
	07/27/23	Termination of contract with GEO Reentry Services LLC, affecting NHP RAE 2's population seeking behavioral health services. Correction for reporting on Turning Point, previously reported as having left the network, affecting NHP RAE 2's population seeking behavioral health services.
	11/07/23	Change in hours of operation for Centennial Mental Health Center's Journey Point Respite Program, affecting members seeking behavioral health and respite care services.
RAE 4	06/12/23	Termination of PCMP provider, impacting members seeking access to primary care services.
	07/26/23	Termination of contract with the Chanda Center for Health, affecting HCI RAE 4's population seeking behavioral health services. Termination of contract with Nuleaf Counseling Center, affecting HCI RAE 4's population seeking behavioral health services.
	12/19/23	Termination of two PCMP providers in Pueblo and Conejos counties, impacting members seeing primary care services.

HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid services in Colorado and presented findings and assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the assessed MCEs. Additionally, HSAG determined that all MCEs had acceptable data collection procedures. Half of the MCEs did not rely on an external delegated entity for NA indicator reporting during the reporting period. For the MCEs which did utilize external delegated entities to complete NA indicator reporting during the reporting period, no issues were identified requiring correction within the last year.

Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the MCEs' interpretation of data was accurate. The following table presents the HSAG calculated validation ratings for each of the eight MCEs.

MCE[2]	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
CCHA	85.2%	14.8%	0%	0%
COA	73.4%	26.6%	0%	0%
DentaQuest	100%	0%	0%	0%
DHMP	44.4%	55.6%	0%	0%
Kaiser	6.0%	44.8%	0%	49.3%
NHP	65.2%	34.8%	0%	0%
HCI	65.2%	34.8%	0%	0%
RMHP	100%	0%	0%	0%

[1] The percentages presented in the tables are based on the total number of indicators assessed and what percentage of the indicators scored High, Moderate, Low, or No Confidence/Significant Bias overall. The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

[2] MCEs with multiple lines of business (e.g., COA is COA CHP+, RAE 3 and RAE 5) were evaluated together and received the same validation rating.

ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases of activities: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the MCEs, HSAG obtained all Department-defined network adequacy standards and indicators that the Department requires for validation.

HSAG prepared a document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCEs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. Data and documentation from the MCEs such as, but not limited to, network data files or directories and member enrollment files, were obtained through a single documentation request packet provided to each MCE.

HSAG hosted an MCE-wide webinar focused on providing technical assistance to the MCEs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

Validation activities were conducted via interactive virtual review and are referred to as "virtual review," as the activities are the same in a virtual format as in an on-site format.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA by using each MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCE tracks providers over time, across multiple office locations, and through changes in participation in the MCE's network. The ISCAT was used to assess the ability of the MCE's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required each MCE that calculated the Department-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the Department-defined performance indicator specifications. HSAG identified whether the required variables were in alignment with the Department-defined indicators used to produce the MCE's indicator calculations. HSAG required each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCE took for indicator calculation.
- **Validate network adequacy data and methods:** HSAG assessed data and documentation from MCEs that included, but was not limited to, network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results:** HSAG assessed the MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and Department network adequacy monitoring results. HSAG validated network adequacy reporting against Department-defined indicators and against the most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and if the MCE's interpretation of the data was accurate.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and

data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

The Department has made significant progress since the initial development in FY 2019-2020 and implementing quarterly network adequacy reporting materials that are standardized within and across MCE types. The Department has taken a critical look at provider data availability, made progress in receiving routine provider files with standard category mapping from MCEs, and validating the MCEs' quarterly time distance reporting results.

The Department will continue to refine and automate the quarterly network adequacy reporting to reduce duplication of reporting and oversight efforts for the Department and MCEs and to facilitate routine Network Adequacy Validation by an external entity. In addition, the Department will consider conducting an independent network directory review to verify that the MCEs' publicly available network data accurately represent the network data supplied to the members and used for geo access analyses. The Department will continue to assess the number, distribution and availability of the MCEs' network locations and look at a variety of other access related topics (e.g. which providers offer telemedicine). The Department will continue to review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care. Survey results and grievance and appeals data is utilized to evaluate the degree to which members are satisfied with the care they have received and the extent to which unsatisfactory care may be related to an MCE's lack of compliance with network standards.

§438.207(b)(2) Contractors are required to provide a Network Adequacy Report Annually which details each health plan's ability to deliver the benefits promised by providing reasonable access to enough in network primary care and specialty physicians with unreasonable delay. Network Adequacy Reports are located at: https://hcpf.colorado.gov/accountable-care-collaborative-deliverables. In addition, the Department continues to expand provider networks throughout the state to ensure all Health First Colorado Members have access to care.

EQR Dashboard

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, NAV ratings, and PIPs.

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, NAV ratings, 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 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, NAV ratings, and PIPs.

This dashboard allows the user to assess health plan performance on performance measures and/or CAHPS at different levels of aggregation (measure, indicator) to facilitate identification of high and lower performers.

For each MCE, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2023–2024. HSAG then analyzed the data to determine whether 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.

Other Quality Improvement Initiatives

Hospital Transformation Program (HTP): HTP is in year four of the five-year program. Hospitals have received evaluations on their program year three interim activity and Community Health & Neighborhood Engagement (CHNE) progress through September 2024. Within HTP, 26 hospitals select statewide and local measures to be evaluated over the course of the program. As the program continues the transition to pay for achievement, performance and improvement, hospitals will continue to be responsible for more complex reporting on their milestone achievements and driving performance improvements on their selected measures. The HTP's first pay-for-performance year started in October 2023 and continues through September 2024.

The Hospital Transformation Program is a five-year program that was launched in April of 2021. There were 83 hospitals that were a part of the original application process, and that number has now grown to 84 hospitals enrolled in the HTP. Hospitals participating in the Hospital Transformation Program (HTP) must submit an Implementation Plan detailing the strategies and steps they intend to implement for each intervention(s) outlined in their applications.

- Cumulative summary of current HTP activities:
- 84 Hospitals continue to submit interim activity on time.
- 95% of hospitals are on track to hit all their year four milestones.
- Over 13,000 interim activities across hospital interventions.
- Over 4,800 unique Community Health & Neighborhood Engagement (CHNE) activities.
- Over 3,750 consultations with key stakeholders.
- Over 800 community advisory meetings.
- 260 public engagement meetings.

As of October 1, 2024, HCPF notified hospitals of final scores for timeliness and completeness for the quarter ending September 2024, Interim Activity and CHNE Quarterly Reporting scores. All 84 hospitals in this reporting quarter were considered timely; 82 hospitals were considered complete for their Interim Activity reporting; and 84 hospitals were considered complete for their CHNE Activity reporting. Therefore, 82 hospitals earned the available 0.5% of the at-risk funds for this quarter of reporting. For more information on the HTP, visit the site at this link here.

Hospital Quality Improvement Program (HQIP)

As part of the Value-Based Payment (VBP) effort for hospitals, Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) includes a provision to establish HQIP funded by the healthcare affordability and sustainability fee to improve the quality of care provided in Colorado hospitals. At the request of the CHASE Board, the HQIP subcommittee recommends the approach for quality incentive payments.

The HQIP subcommittee seeks to:

- Adopt measures that can be prospectively set to allow time for planning and successful implementation
- Identify measures and methodologies that apply to care provided to Health First Colorado members
- Adhere to value-based purchasing principles
- Maximize participation in Health First Colorado
- Minimize the number of hospitals which would not qualify for selected measures.

The payments earned for each of the measures are based on points per Health First Colorado adjusted discharge. Health First Colorado adjusted discharges are calculated by multiplying total Health First Colorado discharges by an adjustment factor. The adjustment factor is calculated by dividing total Health First Colorado gross charges by Health First Colorado inpatient service charges and multiplying the result by the total Health First Colorado discharges. The adjustment factor is limited to five. For purposes of calculating Health First Colorado adjusted discharges, if a hospital has less than 200 Health First Colorado discharges, those discharges are multiplied by 125% before the adjustment factor is applied. Each hospital's HQIP payment is calculated as quality points awarded, multiplied by Health First Colorado adjusted discharges, multiplied by dollars per adjusted discharge point. Dollars per adjusted discharge point are tiered so that hospitals with more quality points awarded receive a greater per adjusted discharge point reimbursement. The dollars per adjusted discharge point for the five tiers are shown below:

FFY 2021-22

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.82
2	40-59	$5.64
3	60-79	$8.46
4	80-100	$11.28

During the FFY 2021-22 timeframe, HQIP payments totaled over $104 million with 80 hospitals receiving payments.

FFY 2022-23

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.46
2	40-59	$4.92
3	60-79	$7.38
4	80-100	$9.84

During the FFY 2022-23 timeframe, HQIP payments totaled over $119 million with 80 hospitals of receiving payments.

FFY 2023-24

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.07
2	40-59	$4.14
3	60-79	$6.21
4	80-100	$8.28

During the FFY 2023-24 timeframe, HQIP payments totaled over $128 million with 82 hospitals receiving payments. For more information on HQIP, visit the site below at this link here.

Program of All-Inclusive Care for the Elderly (PACE)

The Department continues to review each PACE organization's compliance with the requirements of 42 CFR Part 460, including the organization's capacity to provide comprehensive medical and social services to elderly individuals who enroll in the PACE program. While services are furnished across all settings, a primary PACE program objective is to enable participants to live in the community rather than a skilled nursing facility. As part of the review process the Department implemented two (2) uniform surveys to identify areas of opportunity to improve the delivery of services, participant care and overall member satisfaction and experience. For fiscal year 2019-2020, the top three (3) satisfaction concerns identified are:

1. Communication
2. Care Coordination (including lack of follow-up on test results)
3. Specialist (not seen as soon as needed)

The Department Continues to work with PACE organizations to further drive improvement in initiating various performance improvement projects.

Section 4: Conclusion

Improving the experience of patient care, improving population health, and reducing per capita costs of health care are all key priorities of the Department. To assist the Department in driving performance improvement all contracted health plans are provided with their individual scores; an assessment of their strengths and weaknesses; and recommendations or required corrective actions for improving quality, timelines, and access to care and services. Health plans are required to take steps that will improve their performance. In addition, the Department continues to identify and incorporate principles of quality improvement initiatives to further achieve an enhanced level of performance which is reliable and cost-effective while providing sustainable processes for achieving identified goals of improving care delivery and enhancing member outcomes.