COLORADO

Department of Health Care Policy & Financing

FY 2023–2024 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

January 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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1. Executive Summary

Report Purpose and Overview

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations at Title 42 of the Code of Federal Regulations (42 CFR) §438.356 require states to contract with an external quality review organization (EQRO), and 42 CFR §438.358 requires the EQRO to aggregate and analyze results in an annual detailed technical report pursuant to §438.364 that summarizes findings on quality, timeliness, and access to healthcare services that managed care entities (MCEs) furnish to the State's Medicaid and CHIP members. The end product of this analysis is the annual external quality review (EQR) technical report. The Colorado Department of Health Care Policy & Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to comply with these regulations. This annual EQR technical report includes results of all mandatory and optional EQR-related activities that HSAG conducted with Colorado's Medicaid health plans throughout fiscal year (FY) 2023–2024.

Colorado's Medicaid Managed Care Program

Health First Colorado, Colorado's Medicaid program, is comprised of seven Regional Accountable Entities (RAEs) and two managed care organizations (MCOs). In 2011, the Department established the Accountable Care Collaborative (ACC) Program as a central part of Colorado's plan for Medicaid reform. Effective July 1, 2018, the Department implemented ACC Phase II and awarded contracts to the seven RAEs. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service (FFS) primary care providers (PCPs) and capitated behavioral health (BH) providers to ensure access to both BH and primary care for Medicaid members through one accountable entity per region. The RAEs meet the federal definition of prepaid inpatient health plans (PIHPs), and as such are required to comply with Medicaid managed care regulations at 42 CFR Part 438. FY 2023–2024 was the sixth year of RAE operations. Colorado's two MCOs provide services under a capitated contract with the Department. The RAEs and DHMP provide physical health (PH) and mental health (MH) services under a 1915b waiver and substance use disorder (SUD) services under an 1115 waiver. RMHP Prime provides services under Colorado's 1915b waiver.

Colorado's Medicaid MCEs are as follows.

Table 1-1—Colorado Medicaid Health Plans

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

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

Scope of EQR Activities for Colorado's MCEs

Table 1-2 shows the mandatory and optional EQR-related activities HSAG conducted in FY 2023–2024.

Table 1-2—FY 2023–2024 EQR Activities Conducted

Activity Description/Protocol Number	Participating MCEs
Mandatory Activities	
Validation of Performance Improvement Projects (PIPs) (Protocol 1)	
HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.	RAEs and Medicaid MCOs
Validation of Performance Measures (PMV) (Protocol 2)	
HSAG validated performance measures, used for the behavioral health incentive program (BHIP), to assess the accuracy of performance measures reported by the RAEs. The validation also determined the extent to which performance measures, which were calculated by the Department, followed specifications as stated in the Department's RAE BHIP specifications document.	RAEs
HEDIS/Centers for Medicare & Medicaid Services (CMS) Core Set Measure Rate Validation (Protocol 2)	
To assess the accuracy of the performance measures reported by or on behalf of the MCOs, each MCO's licensed HEDIS auditor validated each performance measure selected by the Department for review. The validation also determined the extent to which performance measures calculated by the MCOs followed specifications required by the Department.	Medicaid MCOs
Assessment of Compliance With Medicaid Managed Care Regulations (Compliance With Regulations) (Protocol 3)	
Compliance activities were designed to determine the RAEs' and MCOs' compliance with State and federal managed care regulations and related Department contract requirements. HSAG assessed compliance through review of four standard areas approved by the Department.	RAEs and Medicaid MCOs
Validation of Network Adequacy (NAV) (Protocol 4)	
Each quarter, HSAG validated each health plan's self-reported compliance with minimum time and distance network requirements and collaborated with the Department to update the quarterly network adequacy reporting materials used by the health plans.	RAEs and Medicaid MCOs

Activity Description/Protocol Number	Participating MCEs
For the Information Systems Capabilities Assessment (ISCA) activity, HSAG collected and evaluated the capabilities of each MCE's information systems (IS) infrastructure to monitor network standards.	
Optional Activities	
Encounter Data Validation (EDV)—RAE 411 Over-Read (Protocol 5)	
HSAG sampled records audited by the RAEs and DHMP during the MCEs' own encounter data audit. HSAG conducted an over-read of the sampled records to validate the MCEs' EDV results. HSAG reviewed the encounter data to ensure that medical record documentation supported the MCEs' encounter data submissions to the Department.	RAEs and DHMP
EDV—MCO 412 Over-Read (Protocol 5)	
HSAG sampled records audited by the Medicaid MCOs during the MCOs' own encounter data audit. HSAG conducted an over-read of the sampled records to validate the MCOs' EDV results. HSAG reviewed the encounter data to ensure that medical record documentation supported the MCOs' encounter data submissions to the Department.	Medicaid MCOs
CAHPS Surveys—RAEs (Protocol 6)	
HSAG annually administers the CAHPS 5.1H Adult Medicaid Health Plan Survey with the HEDIS supplemental item set and CAHPS 5.1H Child Medicaid Health Plan Survey with the HEDIS supplemental item set and Children with Chronic Conditions (CCC) measurement set to parents/caretakers of child Medicaid members enrolled in the seven RAEs. HSAG calculated the adult and child survey results included in this report.	RAEs
CAHPS Surveys—MCOs (Protocol 6)	
Each MCO was responsible for conducting a CAHPS survey of its members and forwarding the data to HSAG for the calculation and validation of the results included in this report.	Medicaid MCOs
Quality Improvement Plans (QUIPs) (Protocol 8)	
Following the EDV 411 and 412 over-read audits, each health plan is required to design a QUIP to target findings of low encounter data accuracy or low agreement results (under 90 percent) within its own service coding accuracy reports and HSAG's over-read. HSAG tracks and monitors each QUIP to ensure the improvement interventions are appropriately designed and outcomes achieve increased accuracy in encounter data submissions.	RAEs and Medicaid MCOs
Mental Health Parity (MHP) Audits (Protocol 9)	
HSAG monitors the MCEs annually to ensure continued compliance with findings articulated in the Department's MHP analysis. Activities include an annual audit of each MCE's utilization management (UM) program procedures and denial determinations to ensure compliance with federal and State MHP regulations.	RAEs and Medicaid MCOs
Quality of Care (QOC) Grievances and Concerns Audit (Protocol 9)	
HSAG conducted an audit of the MCEs to evaluate processes for managing, investigating, and resolving QOC grievances (QOCGs) and QOC concerns (QOCCs).	RAEs and Medicaid MCOs
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Audits (Protocol 9)	
HSAG conducted a document review and record review to determine compliance with federal and state-specific EPSDT regulations and contract requirements regarding authorization of services covered under EPSDT and outreach requirements.	RAEs and DHMP

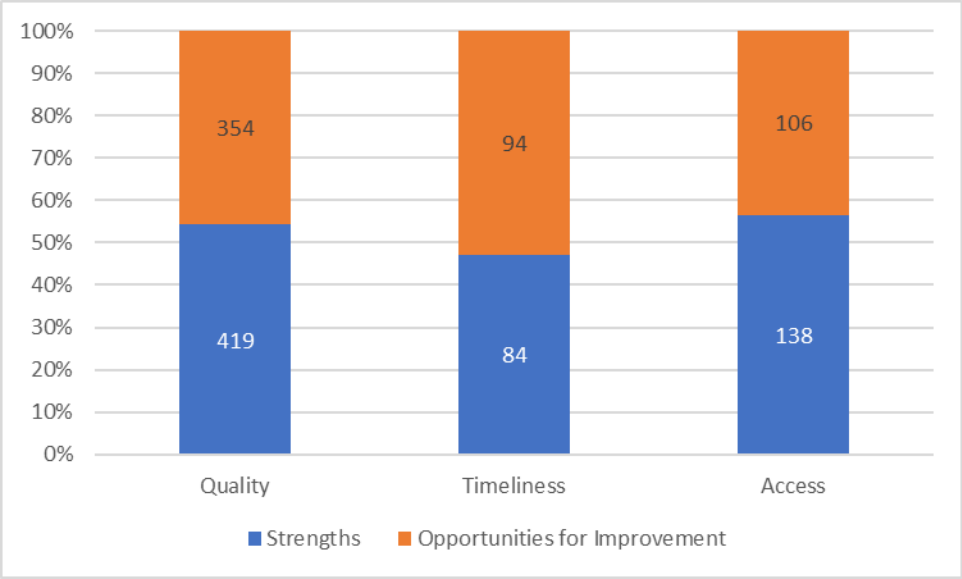
Activity Description/Protocol Number	Participating MCEs
SUD UM Over-Read (Protocol 9)	
In accordance with Senate Bill (SB) 21-137 Section 11, HSAG audited 33 percent of all denials of requests for authorization for inpatient and residential SUD services.	RAEs and DHMP
EQR Dashboard (Protocol 9)	
HSAG designed the EQR Dashboard to allow the Department to monitor and track the MCEs' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, MHP Audit compliance scores, and PIPs.	RAEs and Medicaid MCOs

This report includes the results of EQR-related activities conducted for the MCEs in FY 2023–2024. Colorado does not exempt any of its MCEs from EQR. However, the Department combined reviews during the EPSDT optional EQR activity for one organization operating multiple MCEs to avoid duplication effort.

Summary of FY 2023–2024 Statewide Performance Related to Quality, Timeliness, and Access

Figure 1-1 provides an overall assessment of the number of strengths and weaknesses (opportunities for improvement) that HSAG assessed as likely to impact each of the care domains of quality, timeliness, and access. These counts were derived from the results of all mandatory and optional EQR-related activities conducted for all Health First Colorado MCE types during FY 2023–2024.

Figure 1-1—Number of Strengths and Opportunities for Improvement



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

Statewide Recommendations Related to Quality, Timeliness, and Access

The MCEs demonstrated moderate to strong compliance and performance for EQR activities such as Validation of Performance Improvement Projects, Assessment of Compliance With Medicaid Managed Care Regulations, Validation of Network Adequacy, Encounter Data Validation, Quality Improvement Plans, Mental Health Parity Audit, and QOC Grievances and Concerns Audit. However, HSAG identified opportunities for improvement in the Validation of Performance Measures and CAHPS Surveys EQR activities. As each EQR activity is comprised of multiple strengths and opportunities for improvement, HSAG noted similarities between the percentage of strengths and opportunities for improvement across quality, timeliness, and access; there was low to moderate variation in the range of strengths across the MCEs, which ranged from 37 to 62 per MCE for quality, seven to 13 for timeliness, and 10 to 20 for access. HSAG noted that RMHP Region 1 had the highest number of strengths across quality, timeliness, and access.

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

2. Reader's Guide

How This Report Is Organized

Section 1—Executive Summary provides the purpose and overview of this annual EQR technical report, includes a brief introduction to Health First Colorado, and describes the authority under which Colorado's MCEs provide services. This section also describes the EQR activities conducted during FY 2023–2024 and includes graphics that depict the percentages of strengths and opportunities for improvement—derived from conducting mandatory and optional EQR activities in FY 2023–2024—that relate to the care domains of quality, timeliness, and access. In addition, this section includes any conclusions drawn and recommendations made for statewide performance improvement.

Section 2—Reader's Guide describes the background of federal regulations and the authority under which the report must be provided; an overview of the methodology for each EQR activity performed; and how HSAG obtained, aggregated, and used the data obtained to draw conclusions as to the quality, timeliness, and accessibility of care provided by Colorado's Medicaid managed care health plans.

Section 3—Statewide Comparative Results, Assessment, Conclusions, and Recommendations includes statewide comparative results organized by EQR-related activity. Three-year trend tables (when applicable) include summary results and statewide averages. This section also identifies, through presentation of results for each EQR activity, trends and commonalities used to derive statewide conclusions and recommendations. In addition, this section includes an assessment of how the Department can target the goals and objectives of the State's Managed Care Quality Strategy to better support the improvement of the quality, timeliness, and accessibility of healthcare provided by the Medicaid health plans.

Section 4—Evaluation of Colorado's Medicaid Managed Care Health Plans provides summary-level results for each EQR-related activity performed for the RAEs and MCOs. This information is presented by health plan and provides an EQR-related activity-specific assessment of the quality, timeliness, and accessibility of care and services for each health plan as applicable to the activities performed and results obtained. This section also provides for each health plan, by EQR activity, an assessment of the extent to which each health plan was able to follow up on and complete any recommendations or corrective actions required as a result of the FY 2022–2023 EQR-related activities.

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

Definitions

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

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[1]

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[3]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[1]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the health plan designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 18, 2024.

methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the health plan improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the health plans with specific feedback and recommendations. The health plans used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with the CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the health plan adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each health plan. HSAG then identified common themes and the salient patterns that emerged across the health plans related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed CMS EQR Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the health plans, HSAG assigned each PIP topic to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-1.

Table 2-1—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Health Plan	PIP Topic	Quality	Timeliness	Access
RMHP	*Follow-Up After Hospitalization for Mental Illness [FUH] 7-Day and 30-Day in RAE BH [Behavioral Health] Members*	✓	✓	✓
	Improving the Rate of SDOH [Social Determinants of Health] Screening for RAE Members in Region 1	✓		
NHP	*Follow-Up After Emergency Department Visits for Substance Use [FUA]: Ages 13 and Older*	✓	✓	✓
	Screening for Social Determinants of Health (SDOH)	✓		
COA Region 3	*Follow-Up After Hospitalization for Mental Illness (FUH)*	✓	✓	✓
	Social Determinants of Health (SDOH) Screening	✓		
HCI	*Follow-Up After Emergency Department Visits for Substance Use [FUA]*	✓	✓	✓
	Social Determinants of Health (SDOH) Screening	✓		
COA Region 5	*Follow-Up After Hospitalization for Mental Illness (FUH)*	✓	✓	✓
	Social Determinants of Health (SDOH) Screening	✓		
CCHA Region 6	*Follow-Up After Hospitalization for Mental Illness (FUH)*	✓	✓	✓
	Social Determinants of Health (SDOH) Screening	✓		
CCHA Region 7	*Follow-Up After Hospitalization for Mental Illness (FUH)*	✓	✓	✓
	Social Determinants of Health (SDOH) Screening	✓		

Health Plan	PIP Topic	Quality	Timeliness	Access
DHMP	*Improving Well-Care Visit [WCV] Rates for Child and Adolescent DHMP Medicaid Members*	✓		✓
	Improving Social Determinants of Health [SDOH] Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services	✓		
RMHP Prime	*Diabetes A1c Poor Control for Prime MCE [Managed Care Entity] Members*	✓		
	Improving the Rate of SDOH [Social Determinants of Health] Screening for Prime Members	✓		

Validation of Performance Measures for RAEs

Objectives

The primary objectives of the performance measure validation (PMV) process were to:

- Evaluate the accuracy of BH performance measure data reported by the RAE.
- Determine the extent to which the specific performance measures reported by the RAE (or on behalf of the RAE) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

The Department selected the performance measures for calculation and completed the calculation of all measures. Calculation of the measures was accomplished by using a number of data sources, including claims/encounter data and enrollment/eligibility data.

HSAG conducted PMV for each RAE's measure rates. The Department required that the measurement year (MY) 2023 (i.e., July 1, 2022, through June 30, 2023) performance measures be validated during FY 2023–2024 based on the specifications outlined in the *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2022–2023*, which was written collaboratively by the RAEs and the Department.[2] This document contained both detailed information related to data collection and rate calculation for each measure under the scope of the audit and reporting requirements, and all measure rates calculated using these specifications originated from claims/encounter data. For FY 2022–2023 calculation of measures, measures were developed by the Department and the RAEs, collaboratively.

[2] Colorado Department of Health Care Policy and Financing. *Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2022–2023.*

HSAG's process for PMV for each RAE included the following steps.

Pre-Review Activities: Based on the measure definitions and reporting guidelines provided by the Department, HSAG:

- Developed measure-specific worksheets that were based on the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 2),[3] and were used to improve the efficiency of validation work performed.
- Developed an Information Systems Capabilities Assessment Tool (ISCAT) that was customized to Colorado's service delivery system and was used to collect the necessary background information on the Department's IS, policies, processes, and data needed for the virtual site performance of validation activities, as they relate to the RAEs. HSAG included questions to address how encounter data were collected, validated, and submitted to the Department.
- Reviewed other documents in addition to the ISCAT, including source code for performance measure calculation, prior performance measure reports, and supporting documentation.
- Performed other pre-review activities including review of the ISCAT and supporting documentation, scheduling and preparing the agenda for the virtual site visit, and conducting conference calls with the Department to discuss the virtual site visit activities and to address any ISCAT-related questions.

Virtual Review Activities: HSAG conducted a virtual site visit for the Department to validate the processes used for calculating the incentive performance measure rates. The virtual review included:

- An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- An evaluation of system compliance, including a review of the ISCAT, focusing on the processing of claims, encounters, and member and provider data. HSAG performed primary source verification (PSV) on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data system. Additionally, HSAG evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- A review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with key Department staff members, allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed.
- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 18, 2024.

for reporting the selected performance measures. HSAG performed PSV to further validate the output files, and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.

- A closing conference to summarize preliminary findings from the review of the ISCAT and the virtual review, and to revisit the documentation requirements for any post-review activities.

Description of Data Obtained

As identified in the CMS EQR Protocol 2, HSAG obtained and reviewed the following key types of data for FY 2023–2024 PMV activities:

- **ISCAT:** This was received from the Department. The completed ISCAT provided HSAG with background information on the Department's IS, policies, processes, and data in preparation for the virtual validation activities.
- **Source Code (Programming Language) for Performance Measures:** This was obtained from the Department and was used to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports:** These were obtained from the Department and were reviewed to assess trending patterns and rate reasonability.
- **Supporting Documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results:** HSAG obtained the results from the measures the Department calculated on behalf of each of the RAEs.
- **Virtual Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Department staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

Information Systems Standards Review

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS EQR Protocol 2, HSAG gave a validation finding of *Report*, *Not Reported*, or *No Benefit* to each performance measure. HSAG based each validation finding on the magnitude of errors detected for

the measure's evaluation elements, not by the number of elements determined to be noncompliant. Consequently, it was possible that an error for a single element resulted in a designation of *Not Reported* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that errors for several elements had little impact on the reported rate and that the indicator was thereby given a designation of *Report*.

Performance Measure Results

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

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

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

The RAEs' MY 2023 performance measure rates were compared to the Department's established performance targets and are denoted in Table 2-3.

Table 2-3—MY 2023 Performance Targets

Performance Measure	Performance Target*
Engagement in Outpatient SUD Treatment	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	40.14%
Follow-Up After a Positive Depression Screen	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	36.42%

**Performance targets are specified in the Regional Accountable Entity Behavioral Health Incentive Program (BHIP) Specification Document SFY 2022–2023.*

HEDIS/Core Set Measure Rate Validation—MCOs

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

DHMP and RMHP Prime had existing business relationships with NCQA Licensed Organizations (LOs) that conducted HEDIS audits for their other lines of business (LOBs). The Department allowed the MCOs to use their existing NCQA LOs to conduct the audit in line with the HEDIS Compliance Audit policies and procedures. The HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the MCOs' processes than do the requirements for validating performance measures as set forth by CMS. Therefore, using the HEDIS audit methodology complied with both NCQA and CMS specifications, allowing for a complete and reliable evaluation of the MCOs.

The following processes and activities constitute the standard practice for HEDIS audits in MY 2023 regardless of the auditing firm. These processes and activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[4]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap), and any updated information communicated by NCQA to the audit team directly.
- Virtual site review meetings or Webex conferences, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS and non-HEDIS measure data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - PSV.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.

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

  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS and non-HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan's HEDIS and non-HEDIS measure data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS and non-HEDIS MY 2023 rates as presented within the custom rate reporting template completed by the health plan or its contractor.

The MCOs were responsible for obtaining and submitting their respective HEDIS final audit reports (FARs) to HSAG. The HEDIS auditor's responsibility was to express an opinion on each MCO's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the MCOs, it did review the audit reports produced by the LOs.

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for MY 2023 as part of the validation of performance measures:

1. **FARs:** The FARs, produced by the health plans' LOs, provided information on the health plans' compliance to IS standards and audit findings for each measure required to be reported.
2. **Measure Certification Report:** The vendor's measure certification report was reviewed to confirm whether all required measures for reporting had a "pass" status.
3. **Rate Files From Previous Years and Current Year:** Final rates provided by health plans in a custom rate reporting template were reviewed to determine trending patterns and rate reasonability. Please note that all rates HSAG included in this report were those rates according to the Federal Fiscal Year (FFY) 2024 CMS Adult and Child Core Set specifications. Age stratifications for the Core Set measures may differ from HEDIS age stratifications.

How Data Were Aggregated and Analyzed

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

The MCOs' performance measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate. In the performance measure results tables, HEDIS rates shaded green with one caret (^) indicate statistically significant improvement in performance from MY 2022 to MY 2023. HEDIS rates shaded red with two carets (^^) indicate statistically significant declines in performance from MY 2022 to MY 2023. Performance comparisons are based on the Chi-square test of proportions with results deemed statistically significant with a p value < 0.05. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the custom rate reporting template for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for MCO 1
R_1 = the rate for MCO 1
P_2 = the eligible population for MCO 2
R_2 = the rate for MCO 2

Measure results for HEDIS MY 2023 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2022, when available. In the performance measure results tables, an em dash (—) indicates that the rate is not presented in this report, as the Department did not require the health plans to report this rate for the respective submission. This symbol may also indicate that a percentile ranking was not determined, either because the MY 2023 measure rate was not reportable or because the measure did not have an applicable benchmark.

Additionally, the following logic determined the high- and low-performing measure rates discussed within the results:

- High-performing rates are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the national Medicaid 75th percentile without a significant decline in performance from HEDIS MY 2022.
  - Ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2022.
- Low-performing rates are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2022.

Based on the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only. The Department required that all MY 2021, MY 2022, and MY 2023 measures be reported using the administrative methodology only. However, DHMP and RMHP Prime still reported certain measures to NCQA using the hybrid methodology. The hybrid measures' results are found in Table A-1 in Appendix A. When reviewing measure results, the following items should be considered:

- The MCOs capable of obtaining supplemental data or capturing more complete data will generally report higher rates when using only the administrative methodology. As a result, the measure rates presented in this report for measures with a hybrid option may be more representative of data completeness than of measure performance. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks or to prior years' results that were established using administrative and/or MRR data, as results likely underestimate actual performance. Table 2-4 presents the measures in this report that can be reported using the hybrid methodology.

Table 2-4—Core Set Measures That Can Be Reported Using the Hybrid Methodology

HEDIS Measures
Primary Care Access and Preventive Care
Cervical Cancer Screening
Childhood Immunization Status
Immunizations for Adolescents
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Care of Acute and Chronic Conditions
Controlling High Blood Pressure

HEDIS Measures
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)

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

Table 2-5—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for MCOs

Performance Measure	Quality	Timeliness	Access
Primary Care Access and Preventive Care			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Chlamydia Screening in Women	✓		
Colorectal Cancer Screening	✓		
Immunizations for Adolescents	✓		
Lead Screening in Children	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Maternal and Perinatal Health			
Contraceptive Care—All Women	✓	✓	✓
Contraceptive Care—Postpartum Women	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Care of Acute and Chronic Conditions			
Asthma Medication Ratio	✓		
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓		
Concurrent Use of Opioids and Benzodiazepines	✓		
Controlling High Blood Pressure	✓	✓	
HbA1c Control for Patients With Diabetes	✓		
Human Immunodeficiency Virus (HIV) Viral Load Suppression	✓		
Use of Opioids at High Dosage in Persons Without Cancer	✓		

Performance Measure	Quality	Timeliness	Access
Plan All-Cause Readmissions	✓		
Behavioral Health Care			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Antidepressant Medication Management	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)	✓		
Follow-Up After ED Visit for Substance Use	✓	✓	✓
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓
Initiation and Engagement of Substance Use Disorder (SUD) Treatment	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Screening for Depression and Follow-Up Plan	✓		✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Pharmacotherapy for Opioid Use Disorder	✓	✓	✓
Use of Services			
Ambulatory Care: Emergency Department Visits	NA	NA	NA
Plan All-Cause Readmissions	✓		
PQI 01: Diabetes Short-Term Complications Admission Rate	✓		
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	✓		
PQI 08: Heart Failure Admission Rate	✓		
PQI 15: Asthma in Younger Adults Admission Rate	✓		

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

How Conclusions Were Drawn

Information Systems Standards Review

Health plans must be able to demonstrate compliance with IS standards. Health plans' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCO compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. The IS standards are listed as follows:

- IS A—Administrative Data
- IS M—MRR Processes
- IS C—Clinical and Care Delivery Data
- IS R—Data Management and Reporting

In the measure results tables presented in Section 4, MY 2021, MY 2022, and MY 2023 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for MY 2021, MY 2022, and MY 2023, a measure result of *Small Denominator* (*NA*) indicates that the health plan followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the health plan chose not to report the measure.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG divided the federal regulations and State requirements into 12 standards consisting of related regulations and contract requirements. Table 2-6 describes the standards and associated regulations and requirements reviewed for each standard.

Table 2-6—Compliance Standards

Standard Number and Title	Regulations Included	Year Reviewed
Standard I—Coverage and Authorization of Services	438.114 438.210	2022–2023
Standard II—Adequate Capacity and Availability of Services	438.206 438.207	2019–2020 2022–2023
Standard III—Coordination and Continuity of Care	438.208	2021–2022
Standard IV—Member Rights, Protections, and Confidentiality	438.100 438.224	2021–2022
Standard V—Member Information Requirements	438.10	2021–2022 2023–2024
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424	2019–2020 2022–2023
Standard VII—Provider Selection and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610	2020–2021 2023–2024
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines	2020–2021

Standard Number and Title	Regulations Included	Year Reviewed
Standard IX—Subcontractual Relationships and Delegation	438.230	2020–2021 2023–2024
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS)	438.330 438.236 438.240 438.242	2020–2021 2023–2024
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280	2021–2022
Standard XII—Enrollment and Disenrollment	438.3(d) 438.56	2022–2023

For the FY 2023–2024 compliance review process, the standards reviewed were Standard V—Member Information Requirements; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; and Standard X—QAPI, CPGs, and HIS.

Objectives

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

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

Technical Methods of Data Collection

To assess for compliance with regulations for the health plans, HSAG performed the five activities described in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[5] Table 2-7 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

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

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	The Department directed HSAG to conduct all compliance monitoring activities virtually. HSAG used web-based conferencing to conduct the FY 2023–2024 compliance reviews. All protocol activities, requirements, and agendas were followed. Before the virtual compliance review designed to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, and agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the interview portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and the review agenda. The document request included instructions for organizing and preparing the documents related to review of the four standards. Thirty days prior to each scheduled virtual review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the web-based portion of the review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The HSAG review team reviewed all documentation

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 18, 2024.

For this step,	HSAG completed the following activities:
	submitted prior to the interview portion of the review, and prepared a request for further documentation and an interview guide to use during the virtual review.
Activity 3:	**Conduct Virtual Compliance Review**
	• During the interview portion of the review, HSAG met with each health plan's key staff members to obtain a complete understanding of the health plan's level of compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's organizational performance. • HSAG also requested and reviewed additional documents as needed based on interview responses. • At the close of the interview portion of the review, HSAG met with health plan staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved compliance review report templates to compile the findings and incorporate information from compliance review activities. • HSAG analyzed the findings. • HSAG determined strengths, opportunities for improvement, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report templates. • HSAG submitted the compliance review reports to the health plans and the Department for review and comment. • HSAG incorporated the health plans' and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plans and the Department.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider contracts, agreements, manuals, and directories
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks
- Interviews with key health plan staff members conducted on-site or virtually

How Data Were Aggregated and Analyzed

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, virtual interviews conducted with key health plan personnel, and any additional documents submitted as a result of the interviews. HSAG then calculated scores; analyzed scores, looking for patterns of compliance and noncompliance; and compared scores to the health plans' previous performance, looking for trends. HSAG developed statewide tables of performance (see Section 3) to conduct comparisons of health plans and determine if commonalities of performance existed within the review period, and developed long-term comparison of standard scores over the three-year cycle (where available) to determine if the health plans' overall compliance improved across multiple review cycles.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the Medicaid health plans, HSAG determined that each standard reviewed for assessment of compliance was related to one or more of the domains of care (quality, timeliness, or access). Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table 2-8 depicts the relationship between the standards and the domains of care.

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

Compliance Review Standard	Quality	Timeliness	Access
Standard V—Member Information Requirements			✓
Standard VII—Provider Selection and Program Integrity		✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—QAPI, CPGs, and HIS	✓	✓	

Validation of Network Adequacy

HSAG conducted two distinct activities in FY 2023–2024 designed to assist the Department in understanding the adequacy of the provider networks across the State: time and distance analysis and ISCA.

Objectives

Time and Distance Analysis

The purpose of the FY 2023–2024 network adequacy validation (NAV) time and distance analysis was to determine the extent to which HSAG agreed with the MCEs' self-reported compliance with minimum time and distance network requirements applicable to each MCE. As required in 42 CFR §438.350(a), states which contract with MCOs must have a qualified EQRO perform an annual EQR that includes NAV 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 Child Health Plan *Plus* (CHP+) healthcare practitioner, practice group, and entity networks for all MCEs during FY 2023–2024.

HSAG conducted the FY 2023–2024 NAV according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4), confirming each MCE's ability to collect reliable and valid network adequacy monitoring data, to use sound methods to assess the adequacy of its managed care networks, and to produce accurate results to support MCE and Department network adequacy monitoring efforts.

Information Systems Capabilities Assessment

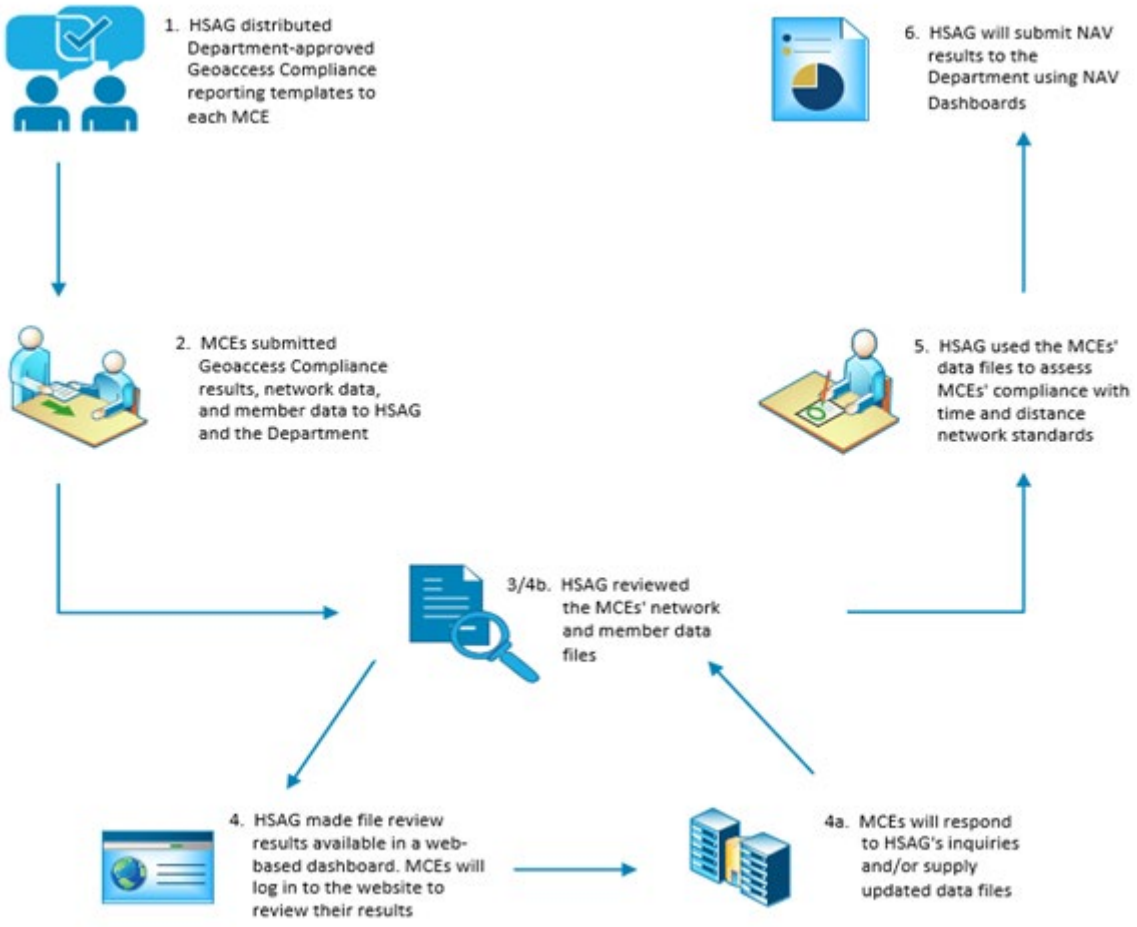
The purpose of the FY 2023–2024 ISCA was to collect and evaluate the capabilities of each MCE's IS infrastructure to monitor network standards in accordance with the requirements of CMS EQR Protocol 4. HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid services in Colorado, and presented findings and assessment of any concerns related to data sources used in the NAV.

Technical Methods of Data Collection

Time and Distance Analysis

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

Figure 2-1—Summary of FY 2023–2024 Process for Time and Distance Analysis



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

HSAG provided the Department-approved geoaccess compliance templates and requested provider network and member data from each MCE. HSAG reviewed each MCE's provider network and member data, iteratively requesting clarifications of data-related questions or updated data files. Once clarified and updated as needed, HSAG performed the network adequacy analyses to assess MCE compliance with minimum time and distance standards. HSAG also developed the network adequacy dashboards for internal use by the Department in QI activities.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the quarterly network adequacy report templates. The provider types (e.g., physician, medical doctor) and specialties (e.g., cardiology, family medicine) listed in the Network Crosswalk were based on MCE data values observed by HSAG. Each MCE was instructed to review its network data values to ensure alignment with the Department's provider categories (e.g., Pediatric Primary Care Practitioner [Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), nurse practitioner (NP), clinical nurse specialists (CNS)], General Behavioral Health). Analyses and templates included, at a

minimum, network categories aligned with the Department's managed care Network Crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[6,7] Table 2-9 presents the provider categories applicable to the MCOs and RAEs; within each category, FY 2023–2024 NAV analyses were limited to categories corresponding to the MCEs' minimum time and distance network requirements.

Table 2-9—Provider Categories by MCE Type

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

In FY 2023–2024, HSAG collaborated with the Department to enhance and maintain a Network Crosswalk and quarterly network adequacy reporting materials, with the goal of standardizing the MCEs' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the MCEs' network adequacy results. On December 15, 2023, HSAG notified each MCE of the January 31, 2024, deadline to submit the FY 2023–2024 Quarter 2 (Q2) network adequacy report and data files. Each MCE's notification included detailed data requirements and an MCE-specific Network Adequacy Quarterly Geoaccess Results Report template containing the MCE's applicable network requirements and contracted counties. To support consistent network definitions across the MCEs and over time, HSAG supplied the MCEs with the Department-approved September 2023 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid member and network files from the Department for members enrolled with a MCE and practitioners, practices,

[6] Network Adequacy Standards, 42 CFR §438.68. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=d748c4b2039bd7ac516211b8a68e5636&mc=true&node=se42.4.438_168&rgn=div8. Accessed on: Nov 19, 2024.

[7] The federal network adequacy standard lists the following provider categories that represent common types or specialties of healthcare providers generally needed within a Medicaid population: primary care, adult and pediatric; obstetrics/gynecology (OB/GYN); BH (MH and SUD), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

and entities enrolled in *interChange*.[8] HSAG requested Medicaid member files from the Department using a detailed member data requirements document for members actively enrolled with an MCE as of December 31, 2023, for FY 2023–2024 Q2. During FY 2023–2024, HSAG used the Department's member and network data each quarter within the enhanced file review process to assess the completeness of the MCEs' member data submissions (e.g., comparing the number of members by county between the two data sources).

Information Systems Capabilities Assessment

HSAG prepared an ISCA 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' IS and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level.

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 IS to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's information technology (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.

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.

Description of Data Obtained

Time and Distance Analysis

Quantitative data for the study included member-level data from the Department and member and provider network data files data from each MCO and RAE, including data values with provider attributes for type (e.g., nurse practitioner), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code. Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid member and provider network files from the Department for members enrolled with an MCE and practitioners, practices, and entities enrolled in *interChange*.

[8] *interChange* is the Department's Medicaid Management Information System (MMIS). All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs.

During the FY 2023–2024 NAV, HSAG also used the Department's member data to compare against the MCEs' member data files (e.g., demographic information and member counts).

Information Systems Capabilities Assessment

HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG assessed data and documentation from the 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. 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 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.

Additionally, 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.

How Data Were Aggregated and Analyzed

Time and Distance Analysis

HSAG used the MCEs' member and provider network data to calculate time/distance and compliance mismatch results for each MCO and RAE for each county in which the MCE had at least one member identified in the MCE's member data file during FY 2023–2024 Q2. HSAG evaluated two dimensions of access and availability: compliance mismatch (i.e., HSAG did not agree with the MCE's quarterly geoaccess compliance results) and geographic network distribution analysis (i.e., time and distance metrics). HSAG calculated these metrics for the network categories for which the Department identified a minimum time and distance access requirement prior to initiation of the analysis.

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

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

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

Following the initial data review and HSAG's receipt of the MCEs' data resubmissions and/or clarifications, HSAG geocoded the member and network addresses to exact geographic locations (i.e., latitude and longitude). Geocoded member and network data were assembled and used to conduct plan type-specific (MCO or RAE) analyses using the Quest Analytics Suite Version 2023.1 software (Quest). HSAG used Quest to calculate the duration of travel time or physical (driving) distance between the members' addresses and the addresses of the nearest provider(s) for the selected network categories.

Consistent with the Department's instructions to the MCEs, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[9] HSAG used the counties listed in the MCEs' member data files to attribute each member to a Colorado county for the county-level time and distance calculations (i.e., the number and percentage of members residing in the specified county with a residential address within the minimum time or distance requirement for the specific network requirement among all applicable providers, regardless of the providers' county). For MCE member records missing the county information, HSAG used the county identified by Quest if the address was an exact match during the geocoding process. Members that could not be attributed to a Colorado county were excluded from the NAV analyses.

Information Systems Capabilities Assessment

HSAG conducted a virtual review with the MCEs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

HSAG evaluated each MCE's IS, focusing on the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCE oversight of external IS, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

[9] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2022. Available at: https://coruralhealth.org/wp-content/uploads/2013/10/2022-county-designations.pdf. Accessed on: Nov 19, 2024.

HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures.

HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source IS matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm the accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by the MCE or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

How Conclusions Were Drawn

Time and Distance Analysis

HSAG used the RAEs' and Medicaid MCOs' quarterly geoaccess compliance reports and member and provider data to perform the geoaccess analysis specific to each MCE. HSAG reviewed the results of the compliance mismatch analysis to identify the percentage of results where HSAG agreed with the MCE's geoaccess compliance results, stratified by county designation. HSAG reviewed the results of the analysis of time and distance requirements to report the percentage of results within the time and distance network requirements, and the percentage of results that did not meet the time and distance requirements. HSAG determined that the NAV activities provided insight into the access domain of care.

Information Systems Capabilities Assessment

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 2-10.

Table 2-10—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have Significant Bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 2-11 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 2-11—Indicator-Level Validation Rating Categories

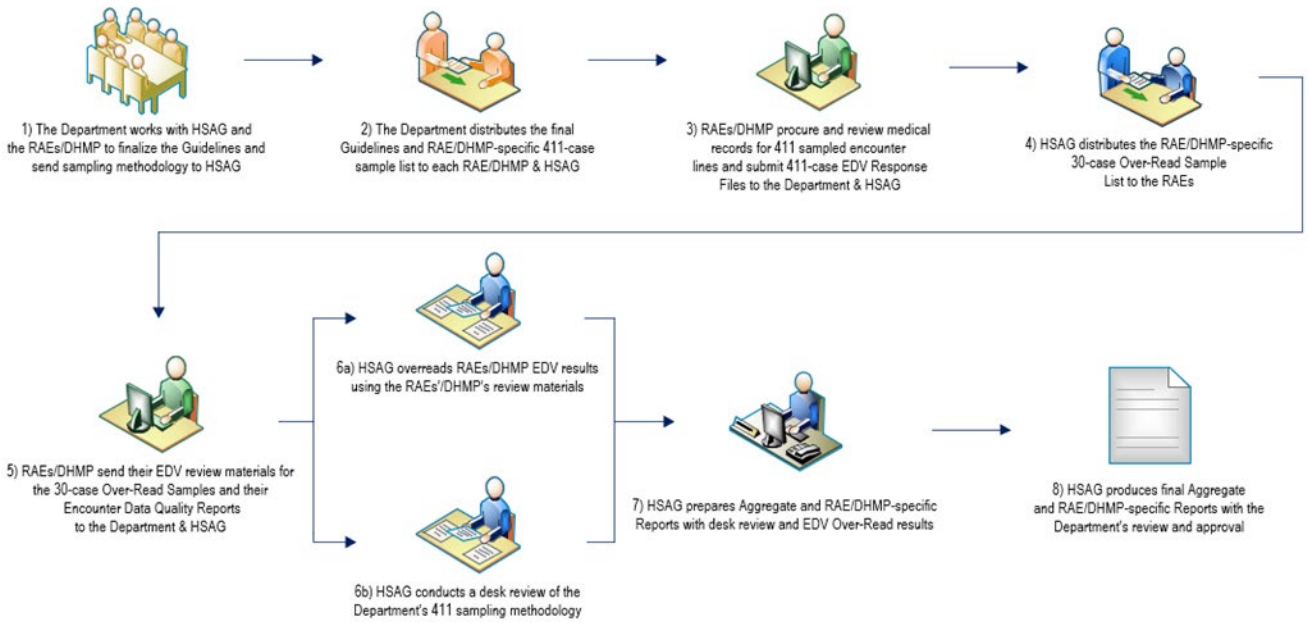
Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low confidence*
Less than 10% and/or any *Not Met* element has Significant Bias on the results	*No Confidence*

Encounter Data Validation—RAE 411 Over-Read

Objectives

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

Figure 2-2—FY 2023–2024 RAE 411 EDV Over-Read Process



Technical Methods of Data Collection

The Department developed the *Annual RAE BH Encounter Data Quality Review Guidelines* to support the RAEs' and DHMP's BH EDVs, including a specific timeline and file format requirements to guide each RAE and DHMP in preparing their annual Encounter Data Quality Reports. To support the BH EDV, the Department selected a random sample of 411 final, paid encounter lines with dates of service between July 1, 2022, and June 30, 2023, from each RAE and DHMP region's BH encounter flat file for each of the following BH service categories: inpatient services, psychotherapy services, and residential services. The RAEs and DHMP reviewed medical records for the sampled 137 cases from each of the three service categories to evaluate the quality of the BH encounter data submitted to the Department.

HSAG reviewed the RAEs' and DHMP's internal audit documentation and overread each RAE's and DHMP's EDV results using MRR among a random sample of each RAE's and DHMP's 411 EDV

cases. HSAG randomly selected 10 encounter lines in each of the three service categories, resulting in an over-read sample of 30 cases per RAE and DHMP.

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

HSAG compared each RAE's and DHMP's self-reported EDV results for each over-read case against the HSAG results to determine overall agreement with service coding accuracy. HSAG entered all over-read results into a standardized data collection tool that aligned with the Department's *Annual RAE BH Encounter Data Quality Review Guidelines*. HSAG tabulated the over-read results by service category to determine the percentage of over-read cases and encounter data elements for which HSAG agreed with the RAEs' and DHMP's EDV responses. HSAG compiled each MCO's self-reported scores and compared against the HSAG over-read sample to determine overall agreement with service coding accuracy. Results were analyzed by service category and encounter data element to review trends within the agreement rates.

How Conclusions Were Drawn

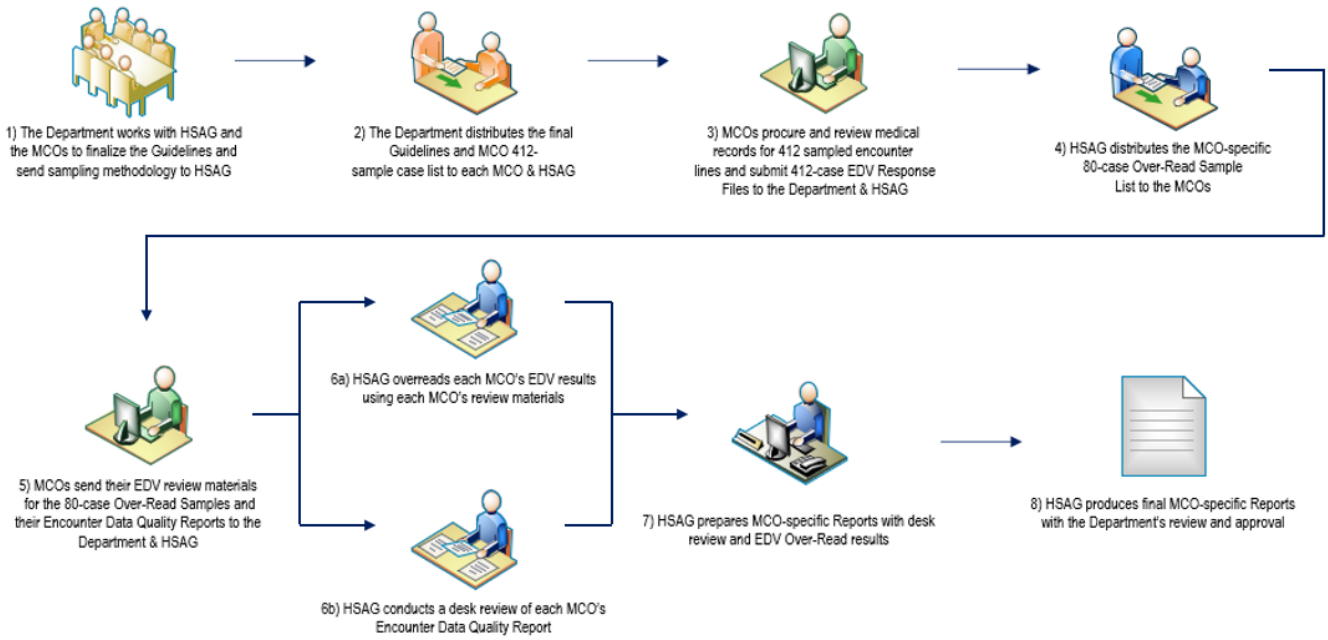
HSAG's over-read evaluated whether the RAEs' and DHMP's internal validation results were consistent with Colorado's Uniform Service Coding Standards (USCS) manuals and standard coding practices specific to the study period. Based on HSAG's level of agreement with each RAE's and DHMP's EDV results for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

Encounter Data Validation—MCO 412 Over-Read

Objectives

The MCO 412 over-read evaluated each MCO's compliance with the Department's encounter data submission standards, as well as the consistency and accuracy with which each MCO used MRR to validate its encounter data. Figure 2-3 diagrams the high-level steps involved in HSAG's MCO 412 EDV over-read process, beginning in the upper left corner of the image.

Figure 2-3—FY 2023–2024 MCO 412 EDV Over-Read Process



Technical Methods of Data Collection

The Department developed the *Annual MCO Encounter Data Quality Review Guidelines* to support the MCOs' EDVs, including a specific timeline and file format requirements to guide each MCO in preparing its annual Encounter Data Quality Report. To support the EDV, the Department selected a random sample of 412 final, adjudicated encounters with dates of service from July 1, 2022, through June 30, 2023, and paid dates between July 1, 2022, and September 30, 2023. The Department randomly sampled 103 cases for each of the following PH service categories: inpatient, outpatient, professional, and Federally Qualified Health Center (FQHC). Each MCO procured and reviewed medical records for each sampled case to evaluate the quality of the encounter data submitted to the Department.

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

HSAG compared each MCO's self-reported EDV results for each over-read case against the HSAG results to determine overall agreement with service coding accuracy. HSAG entered all over-read results into a standardized data collection tool that aligned with the Department's *Annual MCO Encounter Data Quality Review Guidelines*. HSAG tabulated the over-read results by service category to determine the percentage of over-read cases and encounter data elements for which HSAG agreed with the MCOs' EDV responses. HSAG compiled each MCO's self-reported scores and compared against the HSAG over-read sample to determine overall agreement with service coding accuracy. Results were analyzed by service category and encounter data element to review trends within the agreement rates.

How Conclusions Were Drawn

HSAG's over-read evaluated whether the MCOs' internal validation results were accurate based on the review of the encounter data and corresponding medical record documentation. Based on HSAG's level of agreement with each MCO's EDV results for the over-read cases, HSAG determined the extent to which the MCO's self-reported EDV results reflected encounter data quality.

CAHPS Surveys—RAEs and MCOs

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about adult members' and parents'/caretakers' of child members experiences with the healthcare they/their child received.

Technical Methods of Data Collection

For the RAEs, HSAG administered the CAHPS surveys on behalf of the Department. The technical method of data collection occurred through the administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set for the child population. Adult members included as eligible for the survey were 18 years of age or older as of September 30, 2023. Child members included as eligible for the survey were 17 years of age or

younger as of September 30, 2023. All sampled adult RAE members and parents/caretakers of sampled child RAE members completed the surveys from December 2023 to May 2024.

DHMP and RMHP Prime were required to arrange for conducting CAHPS surveys for Medicaid members enrolled in their specific organizations. Each MCO used a certified vendor, SPH Analytics, to conduct the CAHPS surveys on behalf of the MCO. The technical method of data collection occurred through the administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey for the adult population and through the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set for the child population. Adult members included as eligible for the survey were 18 years of age or older as of December 31, 2023. Child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. To support the reliability and validity of the findings, NCQA requires standardized sampling and data collection procedures related to the selection of members and distribution of surveys to those members. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. The MCOs reported that NCQA methodology was followed. DHMP and RMHP Prime provided HSAG with the data to calculate the results presented in this report.

For the RAEs, the survey administration protocol employed was a mixed mode methodology, which allowed for three methods by which adult members and parents/caretakers of child members could complete a survey: (1) mail, (2) Internet, or (3) telephone. A cover letter was mailed to all sampled adult members and parents/caretakers of child members that provided two options by which they could complete the survey in English or Spanish: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey via a URL or quick response (QR) code and designated username. Adult members and parents/caretakers of child members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter and survey. Adult members and parents/caretakers of child members who were not identified as Spanish speaking received an English version of the cover letter and survey. The English and Spanish versions of the first and second cover letters included a toll-free number that respondents could call to request a survey in another language (i.e., English or Spanish). Nonrespondents received a reminder postcard, followed by a second survey mailing and a second reminder postcard. The name of the RAE appeared in the questionnaires and cover letters, the letters included the signature of a high-ranking state official, and the questionnaire packages included a postage-paid reply envelope addressed to the organization conducting the surveys. Computer-assisted telephone interviewing (CATI) was conducted for sampled adult members and parents/caretakers of child members who did not complete a survey. HSAG followed a staggered method of up to six CATI calls to each nonrespondent at different times of the day, on different days of the week, and in different weeks.

For DHMP, a mixed mode methodology (i.e., mailed surveys followed by telephone interviews of nonrespondents with up to three CATI calls) was used for data collection. For RMHP Prime, a mixed mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letters followed by telephone interviews of nonrespondents with up to four CATI calls) was used for data collection. Respondents were given the option of completing the survey in English or Spanish for DHMP and RMHP Prime.

The adult CAHPS survey included 39 items, and the child CAHPS survey included 76 items—all of which assess adult members' and parents'/caretakers' of child members perspectives on healthcare services. The adult survey questions were categorized into 12 measures of experience, which included four global ratings, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation measure items. The child survey questions were categorized into 14 measures of experience, which included four global ratings, four composite measures, one individual item measure, and five CCC composites/items. The global ratings reflected adult members' and parents'/caretakers' overall experience with their/their child's personal doctors, specialists, RAEs/MCOs, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The individual item measure is an individual question that looks at coordination of care. The medical assistance with smoking and tobacco use cessation measure items (adult population only) assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies. The CCC composite and item measures are sets of questions and individual questions that look at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* or *Access to Specialized Services*).[10] If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

For each global rating, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each composite measure, the *Coordination of Care* individual item measure, the *Access to Specialized Services* CCC composite measure (CCC population only), and the *Family-Centered Care (FCC): Getting Needed Information* and *Access to Prescription Medicines* CCC item measures (CCC population only), the percentage of respondents who chose a positive or top-box response was calculated. Response choices for these measures in the adult and child CAHPS surveys were "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for these measures was defined as a response of "Usually" or "Always." For the *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* CCC composite measures (CCC population only), the percentage of respondents who chose the top-box experience response (a response value of "Yes" from response choices of "Yes" and "No") was calculated.

Three overall scores that assess different facets of providing medical assistance with smoking and tobacco use cessation were calculated for the adult population only. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The FY 2023–2024 and 2022–2023 scores presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. Since HSAG did not administer the CAHPS survey for the RAEs in FY 2020–2021 (i.e., FY 2020–2021 results are not available), the FY 2021–2022 results contain members who responded to the survey and indicated that they were current smokers or

[10] The CCC composite and item measures are only calculated for the CCC population. They are not calculated for the general child population.

tobacco users in FY 2021–2022 only; therefore, the FY 2021–2022 scores presented do not follow NCQA's methodology of calculating a rolling average using two years of results. Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measure items, as the FY 2023–2024 results contain members who responded to the survey and indicated they were current smokers or tobacco users in FY 2023–2024 or FY 2022–2023, the FY 2022–2023 results contain members who responded to the survey and indicated they were current smokers or tobacco users in FY 2022–2023 or FY 2021–2022, and the FY 2021–2022 results contain members who responded to the survey and indicated they were current smokers or tobacco users in FY 2021–2022 only.

How Data Were Aggregated and Analyzed

HSAG stratified the results by the seven RAEs. HSAG followed NCQA methodology when calculating the results.

HSAG performed a trend analysis of the results in which the FY 2023–2024 scores were compared to their corresponding FY 2022–2023 scores to determine whether there were statistically significant differences.[11] Statistically significant differences between the FY 2023–2024 scores and the FY 2022–2023 scores are noted with directional triangles. A RAE's/MCO's score that was statistically significantly higher in FY 2023–2024 than FY 2022–2023 is noted with a green upward triangle (▲). A RAE's/MCO's score that was statistically significantly lower in FY 2023–2024 than FY 2022–2023 is noted with a red downward triangle (▼). A RAE's/MCO's score that was not statistically significantly different between years is not denoted with a triangle.

Also, HSAG performed comparisons of the results to the 2023 NCQA national averages.[12,13,14] Statistically significant differences between the RAEs'/MCOs' scores and the NCQA national averages are noted with arrows. A RAE's/MCO's score that was statistically significantly higher than the NCQA national average is noted with a green upward arrow (↑). A RAE's/MCO's score that was statistically significantly lower than the NCQA national average is noted with a red downward arrow (↓). A RAE's/MCO's score that was not statistically significantly different than the NCQA national average is not denoted with an arrow.

In addition, HSAG performed RAE comparisons of the results. Given that differences in case-mix can result in differences in ratings between RAEs that are not due to differences in quality, the data for the

[11] Since this is the first year the CAHPS survey with the CCC measurement set was administered to parents/caretakers of child RAE members in the State of Colorado, trend results are unavailable for the RAE CCC population.

[12] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

[13] Quality Compass® 2023 data are used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

[14] Quality Compass® data were not available for 2024 at the time this report was prepared; therefore, 2023 data were used for this comparative analysis.

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of services provided by the RAEs/MCOs, HSAG determined that each of the measures was related to one or more of the three domains of care (quality, timeliness, or access). This relationship between the measures and the domains of care is depicted in Table 2-12.

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

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Coordination of Care	✓		
Advising Smokers and Tobacco Users to Quit (adult population only)	✓		
Discussing Cessation Medications (adult population only)	✓		
Discussing Cessation Strategies (adult population only)	✓		
Access to Specialized Services (CCC population only)	✓		✓
FCC: Personal Doctor Who Knows Child (CCC population only)	✓		
Coordination of Care for Children with Chronic Conditions (CCC population only)	✓		
Access to Prescription Medicines (CCC population only)	✓		✓

Quality Improvement Plan (QUIP)

Objectives

The purpose of conducting a QUIP is to improve encounter data accuracy. The QUIP is a structured QI activity that consists of three submission phases: process mapping and FMEA; FMEA priority ranking and proposed interventions; and outcomes, key findings, and conclusions. HSAG developed a template for each MCE to use as the submission document for each of the three phases of this project. HSAG pre-populated each MCE's template with the data elements found to be below 90 percent accuracy or 90 percent agreement during the FY 2022–2023 RAE 411 or MCO 412 EDV audit.

Technical Methods of Data Collection

Phase 1: Process Mapping and FMEA

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

Phase 2: FMEA Priority Ranking and Proposed Interventions

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

Phase 3: Outcomes, Key Findings, and Conclusions

After the proposed interventions were approved by HSAG, each MCE began implementing the interventions over a period of three months (November 2023 through January 2024, unless otherwise indicated) with a selected service agency or provider(s). Each month the MCE tracked the accuracy data percentage for each data element. At the conclusion of the three-month evaluation period, each MCE submitted the outcome data for each data element to HSAG with a narrative report, which included a fully completed QUIP submission form as well as a summary of the outcomes, key findings, and conclusions.

Description of Data Obtained

HSAG obtained the data needed to conduct the QUIP from each RAE 411 or MCO 412 EDV report from FY 2022–2023. Using these reports, HSAG compiled data for all MCEs with self-reported encounter data accuracy scores below 90 percent accuracy or agreement scores below 90 percent, which is the Department's threshold for required participation in the QUIP. The FY 2022–2023 RAE 411 or MCO 412 EDV self-reported accuracy scores were used as the baseline data for the FY 2023–2024 QUIP project and entered into the HSAG QUIP submission form templates and distributed for the MCEs.

For the RAE 411 EDV, data selected were derived from the following three service categories: inpatient services, psychotherapy services, and residential services. Within each claim type, HSAG and the RAEs calculated accuracy rates for the following audit elements (data elements): *Procedure Code*, *Service Category Modifier*, *Diagnosis Code*, *Place of Service*, *Units*, *Service Start Date*, *Service End Date*, *Population*, *Duration*, and *Staff Requirement*.

For the MCO 412 EDV, data selected were derived from the following four service categories: inpatient, outpatient, professional, and FQHC. Within each claim type, the MCOs calculated accuracy rates for the following audit elements (data elements): *Procedure Code*, *Procedure Code Modifier*, *Surgical Procedure Code*, *Diagnosis Code*, *Units*, *Date of Service*, *Through Date*, and *Discharge Status*.

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

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

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

Mental Health Parity Audit

Objectives

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

Technical Methods of Data Collection

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

How Conclusions Were Drawn

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

QOC Grievances and Concerns Audit

Objectives

This report will use the term "QOCG," which will include the subset of QOCCs and potentially significant patient safety issues. In an effort to understand the QOCG activity for the nine MCEs, and to design a robust monitoring mechanism, the Department requested that HSAG develop an audit designed to gather information regarding the processes for addressing QOCGs. This project was designed as a focus study with the goal of providing information to the Department for use in improving monitoring efforts and ultimately resulting in improving the health outcomes of Colorado's Medicaid populations.

Technical Methods of Data Collection

HSAG collected data through a document review, QOCG case review sample, and teleconference interviews.

Description of Data Obtained

Policies, procedures, desktop protocols, process documents, and member and provider informational materials regarding QOCGs were obtained from the MCEs. In addition, HSAG requested that each MCE submit a complete list of all QOCGs that warranted investigation during the review period, whether the final outcome was substantiated or not. HSAG selected a sample of up to 10 cases for review for each MCE. If the MCE had 10 or less cases within the review period, HSAG requested review materials for each case. The MCEs then submitted to HSAG all review materials for each case, which included documentation of investigation of the QOCGs and resolution/outcome documents.

How Data Were Aggregated and Analyzed

HSAG aggregated the results of the document review, record review, and teleconference interviews to develop individualized findings and an overall summary of findings regarding the MCEs' processes for addressing QOCGs.

How Conclusions Were Drawn

The sample of potential QOCG cases were assessed for compliance with the MCE's own policies and procedures and any MCE contract requirements applicable during the review period.

EPSDT Services Audit

Objectives

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

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

Technical Methods of Data Collection

HSAG distributed a desk request to obtain policies, procedures, and other documentation and to assess each MCE's overall adherence to federal and State requirements related to EPSDT procedures. Additionally, HSAG collected two types of data sets. First, HSAG requested a "non-utilizer" data file from the Department that included a list of all EPSDT eligible members who had been continuously enrolled for a 12-month period ending in Q4 of FY 2022–2023 (April 2023–June 2023) and had not received services during the 12-month period. Second, HSAG requested a denial data file from each MCE to obtain a list of all medical necessity denials for EPSDT eligible members.

Description of Data Obtained

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

- UM policies, procedures, desktop aids, and other related materials.
- Initial EPSDT informational materials.
- Assessment templates (new member assessment, risk assessment, special health care needs [SHCN], EPSDT, or others commonly used for new members and EPSDT).
- Specific EPSDT considerations.
- Reports such as outreach plans; quarterly outreach reports; and outreach scripts, flyers, birthday letters, etc.
- Referral, care coordination, or UM logs pertaining to EPSDT services.
- EPSDT trainings for the provider network and MCE staff members.

- Notice of adverse benefit determination (NABD) templates.

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

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

For each denial sample, HSAG obtained the following information:

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

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

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

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

Substance Use Disorder Utilization Management Over-Read

Objectives

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

1. MCEs properly followed American Society of Addiction Medicine (ASAM) criteria when making denial determinations for SUD inpatient hospital and residential levels of care (LOCs).
2. HSAG's reviewers agreed with the denial decisions made by each MCE.

Technical Methods of Data Collection

HSAG requested a data file from each MCE to obtain a list of all denials for inpatient hospital and residential levels of SUD treatment among MCE members. Upon receiving the list of all denials from the MCEs, HSAG reviewed key data fields to assess potential duplication, data completeness, and the distribution of denials by MCE, facility, and ASAM LOC. HSAG used the listing of all denied services for inpatient hospital and residential SUD treatment as a sample frame from which to generate a sample list of cases for each MCE for the over-read activities. HSAG used a random sampling approach to select no less than 33 percent of denials that occurred per MCE, based on the number of unique denials for inpatient hospital and residential SUD treatment in the sample frame for each MCE. In FY 2023–2024, special sampling parameters were added to focus on adolescent, older adult, and Special Connections members. Special Connections is a program for pregnant and parenting members (within one year after delivery). Administrative denials were included but capped at 10 percent of each sample while ensuring all ASAM LOCs were represented. Administrative denials were capped to allow for an in-depth review of medical necessity cases, as ASAM criteria agreement is not applicable to administrative denials. HSAG ensured that the sample cases reflected the widest possible array of denials among facilities, ASAM LOCs, and members.

Before sampling, HSAG counted the number of denials by MCE for inpatient hospital and residential SUD treatment and determined the number of cases needed to meet the 33 percent requirement. Fractional numbers were rounded up to the nearest whole number of cases to ensure a minimum of 33 percent of denials were reviewed. HSAG then randomly selected a representative sample of denials for each MCE using the number of sample cases identified in the sample size determination. Cases were then proportionately distributed based on the number of denials within each LOC. For example, if

28 percent of an MCE's denials were attributed to the 3.1 ASAM LOC, 28 percent of the MCE's cases chosen for over-read will reflect denials attributed to the 3.1 ASAM LOC.

Description of Data Obtained

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

- Member name, date of birth (DOB), and ID number.
- Date of service request and date of determination.
- Requesting facility (provider) information.
- ASAM LOC requested and LOC approved.
- Length of stay (LOS) requested and LOS approved.
- Denial type and denial reason.
- Whether the denial was appealed, went to a State fair hearing, and the outcome.
- Result of the review (i.e., denied, partial, or limited approval).
- ABD information provided to the member and to the provider.
- Copies of information the MCE used to make the UR denial determination, including notes from each reviewer; dates of each review; system notes associated with each point of the review; and documentation of telephonic and/or written communication between reviewers and UR staff, providers, members, and/or authorized representatives.
- Documentation of how the MCE considered each ASAM dimension using the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*[15] when determining medical necessity. The third edition was used for this review due to the FY 2022–2023 time frame of denial samples.
- Documentation as to whether medication-assisted treatment (MAT) was offered as part of the treatment provided.
- Credentials of the MCE's reviewer who made the denial determination.

How Data Were Aggregated and Analyzed

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

- Whether the MCE's reviewer selected the appropriate criteria for the LOC and population (e.g., admissions or continued stay, adult-specific criteria, adolescent-specific criteria, and population-specific criteria for older adults or Special Connections members). Based on the Department's direction, HSAG reviewed for treatment plans or equivalent documentation.

[15] Mee-Lee D, Shulman GD, Fishman MJ, et al., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. American Society of Addiction Medicine; 2013: 17.

- Whether the MCE's reviewer applied the chosen criteria correctly (e.g., following the level-specific criteria or considering interdimensional interactions and comorbidities).
- Whether the information found in the medical records and related documents was sufficient to make an independent UR determination regarding the appropriateness of the prior-authorization request and the accuracy of the MCE determination.
- Whether the UR determination was made within the required time frame.
- Whether HSAG's reviewer agreed/disagreed with the MCE's denial determination.
- Whether clinical denial determinations were made by an MCE reviewer with appropriate credentials and expertise in treating the member's condition.
- Whether potential QOCCs were documented in the case file.

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

How Conclusions Were Drawn

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

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

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

EQR Dashboard

Objectives

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

Performance measures and CAHPS results were evaluated together to form an overall summary score. This information was displayed along with compliance scores, MHP Audit compliance scores, 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.

How Conclusions Were Drawn

Users may use the filtered results to determine how an individual health plan within a program performed based on the health plan's Core Set and CAHPS data.

- The *CAHPS Rating by Plan* table represents the prior years' health plans' overall performance on CAHPS measures, which is not comparable to the *Core Set + CAHPS* stars.
- The *Core Set + CAHPS* table represents the health plans' overall performance on CMS Core Set measures and CAHPS measures, with five stars indicating a highest performing health plan and one star indicating a lowest performing health plan. Star ratings are available based on a health plan's

performance compared to the statewide average and in relation to NCQA Quality Compass national benchmarks.

- The *Compliance* table provides the overall number of metrics in which the statewide standard is met. Additional detail on the specific measure results can be found via the tooltip or by selecting the *Standards* table and the applicable year from the table.
- *MHP* results are provided in a table where a green arrow indicates an improvement in performance from the prior year, while a red arrow indicates a decline in performance. A blue tilde indicates that the score remained unchanged as compared to the previous year.
- *NAV Rating scores* are divided into the ratio indicator and the time/distance indicator confidence levels.
- The *PIP* results are divided into clinical and nonclinical ratings. Additional detail on the ratings can be found via the tooltip.

Aggregating and Analyzing Statewide Data

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.

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

Validation of Performance Improvement Projects

Statewide Results

Table 3-1 shows the FY 2023–2024 statewide PIP results for the RAEs and the MCOs.

Table 3-1—FY 2023–2024 Statewide PIP Results

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
RMHP	*Follow-Up After Hospitalization for Mental Illness [FUH] 7-Day and 30-Day in RAE BH [Behavioral Health] Members*	100%	100%	*High Confidence*	*Not Assessed*		
	Improving the Rate of SDOH [Social Determinants of Health] Screening for RAE Members in Region 1	100%	100%	*High Confidence*	*Not Assessed*		
NHP	*Follow-Up After Emergency Department Visits for Substance Use [FUA]: Ages 13 and Older*	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for Social Determinants of Health (SDOH)	100%	100%	*High Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
COA Region 3	*Follow-Up After Hospitalization for Mental Illness (FUH)*	100%	100%	*High Confidence*	*Not Assessed*		
	Social Determinants of Health (SDOH) Screening	100%	100%	*High Confidence*	*Not Assessed*		
HCI	*Follow-Up After Emergency Department Visits for Substance Use [FUA]*	100%	100%	*High Confidence*	*Not Assessed*		
	Social Determinants of Health (SDOH) Screening	100%	100%	*High Confidence*	*Not Assessed*		
COA Region 5	*Follow-Up After Hospitalization for Mental Illness (FUH)*	100%	100%	*High Confidence*	*Not Assessed*		
	Social Determinants of Health (SDOH) Screening	100%	100%	*High Confidence*	*Not Assessed*		
CCHA Region 6	*Follow-Up After Hospitalization for Mental Illness (FUH)*	100%	100%	*High Confidence*	*Not Assessed*		
	Social Determinants of Health (SDOH) Screening	100%	100%	*High Confidence*	*Not Assessed*		
CCHA Region 7	*Follow-Up After Hospitalization for Mental Illness (FUH)*	100%	100%	*High Confidence*	*Not Assessed*		
	Social Determinants of Health (SDOH) Screening	100%	100%	*High Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
DHMP	*Improving Well-Care Visit [WCV] Rates for Child and Adolescent DHMP Medicaid Members*	100%	100%	*High Confidence*	*Not Assessed*		
	Improving Social Determinants of Health [SDOH] Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services	100%	100%	*High Confidence*	*Not Assessed*		
RMHP Prime	*Diabetes A1c Poor Control for Prime MCE [Managed Care Entity] Members*	100%	100%	*High Confidence*	*Not Assessed*		
	Improving the Rate of SDOH [Social Determinants of Health] Screening for Prime Members	100%	100%	*High Confidence*	*Not Assessed*		

[1] **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.

Statewide Conclusions and Recommendations Related to Validation of PIPs

During FY 2023–2024, the RAEs and MCOs (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. 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 identified the following statewide strengths:

- The MCEs followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- The MCEs reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

Based on the FY 2023–2024 PIP validation activities, HSAG did not identify any statewide opportunities for improvement.

Validation of Performance Measures

Performance Measure Validation—RAEs

Statewide Results

Information Systems Standards Review

HSAG evaluated the Department's accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. All measures were calculated by the Department using data submitted by the RAEs. The data came from multiple sources, including claims/encounter and enrollment/eligibility data. For the current reporting period, HSAG determined that the data collected and reported by the Department followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

In Table 3-2, RAE-specific and statewide weighted averages are presented for rates validated in FY 2023–2024 for data from FY 2022–2023 (MY 2023). Cells shaded green indicate the performance met or exceeded the FY 2022–2023 (MY 2023) performance goal (as determined by the Department).

Table 3-2—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%

Performance Measure	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	Statewide RAE Average
Behavioral Health Screening or Assessment for Children in the Foster Care System	14.86%	14.38%	9.92%	36.59%	25.58%	13.25%	15.73%	17.44%

Statewide Conclusions and Recommendations

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

HSAG recommends that the Department implement the following in partnership with the RAEs:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., High Alert Program [HAP], the Patient-Centered Medical Home [PCMH], the Primary Behavioral Health Care Integration [PBHCI], and the Collaborative Care [CC)] Program).[16]

[16] Mao W, Shalaby R, Agyapong VIO. Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. *Healthcare*. 2023; 11(8):1161. Available at: https://www.mdpi.com/2227-9032/11/8/1161. Accessed on: Nov 21, 2024.

HEDIS/CMS Core Set Measure Rates and Validation—MCOs

Statewide Results

Information Systems Standards Review

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

Performance Measure Results

In Table 3-3, MCO-specific and Colorado Medicaid weighted averages are presented for MY 2023. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the MCOs' eligible populations. For the MCOs with rates reported as *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. Please note that this table presents performance measure rates reported using administrative methodology, while performance measure rates reported using hybrid methodology are presented in Appendix A.

Table 3-3—MY 2023 Statewide Performance Measure Results for MCOs

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Primary Care Access and Preventive Care			
Breast Cancer Screening			
52 to 64 Years	52.05%	50.87%	51.48%
65 to 74 Years	40.18%	51.08%	44.10%
Cervical Cancer Screening			
Total	40.81%	46.96%	43.64%
Child and Adolescent Well-Care Visits			
Total	46.56%	28.72%	46.05%
Childhood Immunization Status			
Combination 3	69.05%	NA	69.05%
Combination 7	64.51%	NA	64.51%
Combination 10	44.33%	NA	44.33%
Chlamydia Screening in Women			
16 to 20 Years	80.86%	38.96%	79.04%
21 to 24 Years	70.89%	45.20%	60.10%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Colorectal Cancer Screening			
46 to 50 Years	16.99%	22.53%	19.23%
51 to 65 Years	29.30%	41.17%	34.45%
66 Years and Older	33.45%	37.74%	34.84%
Developmental Screening in the First Three Years of Life			
Total	68.63%	NA	68.60%
Immunizations for Adolescents			
Combination 1	63.07%	58.82%	63.00%
Combination 2	38.97%	26.47%	38.74%
Lead Screening in Children			
Lead Screening in Children	59.10%	NA	59.10%
Weight Assessment and Counseling for Nutrition and Physical Activity			
Body Mass Index (BMI) Percentile—Total	67.28%	20.12%	66.65%
Counseling for Nutrition—Total	75.55%	32.54%	74.97%
Counseling for Physical Activity—Total	74.79%	25.44%	74.13%
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.62%	NA	58.62%
Well-Child Visits From Age 15 Months to 30 Months—Two or More Well-Child Visits	64.19%	NA	64.19%
Maternal and Perinatal Health			
Contraceptive Care—All Women			
Most or Moderately Effective Contraception (MMEC)—15 to 20 Years	21.30%	30.83%	21.63%
MMEC—21 to 44 Years	19.29%	19.41%	19.35%
Long-Acting Reversible Contraception (LARC)—15 to 20 Years	5.81%	6.77%	5.84%
LARC—21 to 44 Years	4.93%	4.28%	4.63%
Contraceptive Care—Postpartum Women			
MMEC—15 to 20 Years—3 Days	29.79%	NA	25.66%
MMEC—21 to 44 Years—3 Days	25.94%	4.09%	14.91%
MMEC—15 to 20 Years—90 Days	65.96%	NA	61.06%
MMEC—21 to 44 Years—90 Days	54.23%	38.56%	46.32%
LARC—15 to 20 Years—3 Days	13.83%	NA	11.50%
LARC—21 to 44 Years—3 Days	8.74%	0.27%	4.47%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
LARC—15 to 20 Years—90 Days	34.04%	NA	29.20%
LARC—21 to 44 Years—90 Days	25.52%	14.31%	19.86%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care—21 Years and Older	83.86%	52.81%	68.26%
Postpartum Care—21 Years and Older	78.52%	46.54%	62.45%
Timeliness of Prenatal Care—Under 21 Years	80.41%	36.11%	71.74%
Postpartum Care—Under 21 Years	79.05%	47.22%	72.83%
Care of Acute and Chronic Conditions			
Asthma Medication Ratio			
5 to 18 Years	68.24%	NA	68.87%
19 to 64 Years	53.68%	58.58%	56.17%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
3 Months to 17 Years	95.16%	NA	95.20%
18 to 64 Years	72.69%	54.39%	60.09%
65 Years and Older	NA	NA	NA
Concurrent Use of Opioids and Benzodiazepines*			
18 to 64 Years	5.46%	9.90%	7.95%
65 Years and Older	5.88%	20.00%	8.43%
Controlling High Blood Pressure			
18 to 64 Years	51.61%	41.89%	46.59%
65 to 85 Years	58.19%	46.00%	53.70%
HbA1c Control for Patients With Diabetes			
HbA1c Control (<8.0%)—18 to 64 Years	48.64%	44.11%	46.54%
HbA1c Control (<8.0%)—65 to 75 Years	54.73%	50.18%	53.26%
*HbA1c Poor Control (>9.0%)—18 to 64 Years**	41.99%	48.01%	44.79%
*HbA1c Poor Control (>9.0%)—65 to 75 Years**	36.66%	40.79%	38.00%
HIV Viral Load Suppression			
18 to 64 Years	68.19%	0.00%	52.27%
65 Years and Older	80.00%	NA	68.09%
Use of Opioids at High Dosage in Persons Without Cancer*			
18 to 64 Years	4.64%	2.77%	3.50%
65 Years and Older	5.83%	NA	5.37%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Behavioral Health Care			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	52.97%	57.42%	55.49%
Antidepressant Medication Management			
Effective Acute Phase Treatment—18 to 64 Years	66.19%	67.42%	66.97%
Effective Acute Phase Treatment—65 Years and Older	81.08%	NA	81.13%
Effective Continuation Phase Treatment—18 to 64 Years	42.60%	48.41%	46.28%
Effective Continuation Phase Treatment—65 Years and Older	48.65%	NA	45.28%
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)*			
18 to 64 Years	45.06%	49.49%	47.50%
65 to 75 Years	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	88.59%	80.66%	83.27%
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—6 to 17 Years	12.09%	NA	11.70%
7-Day Follow-Up—18 to 64 Years	17.16%	33.24%	24.77%
7-Day Follow-Up—65 Years and Older	NA	NA	NA
30-Day Follow-Up—6 to 17 Years	30.77%	NA	32.98%
30-Day Follow-Up—18 to 64 Years	27.70%	47.96%	37.29%
30-Day Follow-Up—65 Years and Older	NA	NA	NA
Follow-Up After ED Visit for Substance Use			
7-Day Follow-Up—13 to 17 Years	4.44%	NA	4.35%
7-Day Follow-Up—18 to 64 Years	18.13%	23.45%	19.51%
7-Day Follow-Up—65 Years and Older	11.86%	NA	13.51%
30-Day Follow-Up—13 to 17 Years	11.11%	NA	10.87%
30-Day Follow-Up—18 to 64 Years	28.17%	36.86%	30.43%
30-Day Follow-Up—65 Years and Older	20.34%	NA	21.62%
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—6 to 17 Years	NA	NA	NA
7-Day Follow-Up—18 to 64 Years	11.36%	27.16%	24.40%
7-Day Follow-Up—65 Years and Older	NA	NA	NA
30-Day Follow-Up—6 to 17 Years	NA	NA	NA

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
30-Day Follow-Up—18 to 64 Years	20.45%	48.32%	43.45%
30-Day Follow-Up—65 Years and Older	NA	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	42.02%	NA	40.94%
Continuation and Maintenance Phase	NA	NA	45.45%
Initiation and Engagement of Substance Use Disorder Treatment			
Initiation of SUD Treatment—Total—18 to 64 Years	41.81%	38.85%	40.57%
Initiation of SUD Treatment—Total—65 Years and Older	47.56%	40.63%	45.00%
Engagement of SUD Treatment—Total—18 to 64 Years	7.21%	15.17%	10.55%
Engagement of SUD Treatment—Total—65 Years and Older	3.66%	1.04%	2.69%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	77.14%	NA	72.00%
Cholesterol Testing—Total	54.29%	NA	54.00%
Blood Glucose and Cholesterol Testing—Total	54.29%	NA	54.00%
Screening for Depression and Follow-Up Plan			
12 to 17 Years	32.25%	7.86%	31.80%
18 to 64 Years	21.28%	8.32%	16.63%
65 Years and Older	6.98%	2.41%	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	38.92%	71.99%	53.89%
Rate 2: Buprenorphine	33.84%	37.84%	35.65%
Rate 3: Oral Naltrexone	3.66%	3.19%	3.45%
Rate 4: Long-Acting, Injectable Naltrexone	1.32%	0.37%	0.89%
Rate 5: Methadone	1.63%	36.98%	17.63%
Use of Services			
Ambulatory Care: ED Visits			
0 to 19 Years	25.89	40.95	26.12
Plan All-Cause Readmissions			
Observed Rate	10.24%	8.98%	9.79%
Expected Rate	9.69%	10.20%	9.87%
O/E Ratio	1.0567	0.8809	0.9916

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
PQI 01: Diabetes Short-Term Complications Admission Rate			
18 to 64 Years	15.48	7.62	12.26
65 Years and Older	5.57	5.66	5.60
PQI 05: COPD or Asthma in Older Adults Admission Rate			
40 to 64 Years	17.43	5.47	11.91
65 Years and Older	38.97	14.15	29.14
PQI 08: Heart Failure Admission Rate			
18 to 64 Years	25.61	5.81	16.74
65 Years and Older	952.38	16.98	146.31
PQI 15: Asthma in Younger Adults Admission Rate			
18 to 39 Years	2.82	0.34	1.90

**For this indicator, a lower rate indicates better performance.*
— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (< 30) to report a valid rate.

Statewide Conclusions and Recommendations Related to HEDIS Measure Rates and Validation

The following MY 2023 statewide average HEDIS measure rates were determined to be high-performing rates for the MCO statewide weighted average (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2022, or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2022):

- *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10*
- *Chlamydia Screening in Women—16 to 20 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months to 17 Years, 18 to 64 Years*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

The following MY 2023 statewide average HEDIS measure rates were determined to be low-performing rates (i.e., ranked below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2021) for the MCOs:

- *Immunizations for Adolescents—Combination 1*

- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—13 to 17 Years* and *30-Day Follow-Up—13 to 17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6 to 17 Years* and *18 to 64 Years*, and *30-Day Follow-Up—6 to 17 Years* and *18 to 64 Years*
- *Follow-Up After Hospitalization for Mental Illness—18 to 64 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase*
- *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—65 Years and Older*

To address these low measure rates, HSAG recommends:

- The Department partner with the MCOs to consider further analysis of key drivers using a segmentation analysis, where the noncompliant members of each measure are stratified by age, gender, race, geography, and provider. Results of this kind of analysis can help to identify key drivers that could be focal points for member-focused or provider-focused interventions that would be effective with a large proportion of the noncompliant population.
- Due to the high number of BH measures with lower rates, the Department work with the MCOs to consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[17]

[17] Mao W, Shalaby R, Agyapong VIO. Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. *Healthcare*. 2023; 11(8):1161. Available at: https://www.mdpi.com/2227-9032/11/8/1161. Accessed on: Nov 21, 2024.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

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

Table 3-4—Statewide Results for Medicaid RAE Standards

Standard and Applicable Review Years	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	Statewide RAE Average
Standard I—Coverage and Authorization of Services (2022–2023)	94%^	91%v	91%^	94%v	88%^	94%^	94%^	92%^
Standard II—Adequate Capacity and Availability of Services (2022–2023)	92%v	93%v	100%~	86%v	100%~	100%^	100%^	96%v
Standard III—Coordination and Continuity of Care (2021–2022)	100%~	100%^	100%~	100%^	100%^	90%v	90%v	97%^
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	100%^	100%~	100%~	100%~	100%~	100%~	100%~	100%^
Standard V—Member Information Requirements (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 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 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—Subcontractual 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 XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	100%~	86%v	100%^	86%v	100%^	86%^	86%^	92%^
Standard XII—Enrollment and Disenrollment (2022–2023)	100%	100%	100%	100%	100%	100%	100%	100%

** Bold text indicates standards that HSAG reviewed during FY 2023–2024. Scores are compared across three years.*

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

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

~ *Indicates no change from review three years prior.*

Table 3-5 presents the compliance scores for record reviews conducted for each RAE during previous review cycles.

Table 3-5—Summary of Statewide Average Scores for the RAE Record Reviews

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

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

Table 3-6—Statewide Results for MCO Standards in the Most Recent Year Reviewed

Standard and Applicable Review Years	DHMP	RMHP Prime	Statewide MCO Average
Standard I—Coverage and Authorization of Services (2022–2023)	97%	94%^	96%^
Standard II—Adequate Capacity and Availability of Services (2022–2023)	92%^	92%v	92%v
Standard III—Coordination and Continuity of Care (2021–2022)	100%^	100%^	100%^
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	100%~	100%^	100%^
Standard V—Member Information Requirements (2023–2024)*	**83%^**	**100%^**	**92%v**
Standard VI—Grievance and Appeal Systems (2022–2023)	80%v	94%^	87%^
Standard VII—Provider Selection and Program Integrity (2023–2024)*	**94%v**	**100%^**	**97%^**
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%^	100%~	100%^
Standard IX—Subcontractual Relationships and Delegation (2023–2024)*	**25%v**	**75%~**	**50%v**
Standard X—QAPI, CPGs, HIS (2023–2024)*	**100%^**	**100%~**	**100%~**
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.*

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

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

~ *Indicates no change from review three years prior.*

Table 3-7 presents the compliance scores for record reviews conducted for each Medicaid MCO.

Table 3-7—Summary of Statewide Average Scores for Record Reviews

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

Statewide Conclusions and Recommendations Related to Assessment of Compliance

Based on the four standards reviewed in FY 2023–2024, the Medicaid health plans—both the RAEs and MCOs—demonstrated compliance and strengths in the following:

- Provider directories were accessible to members through electronic, paper, downloadable, and printable form, and upon member request.
- The MCEs demonstrated methods for identifying and reporting fraud, waste, or abuse (FWA) to the Department and informed providers of FWA policies through the provider agreements and provider manuals, and to staff members through onboarding and annual trainings.
- Some MCEs described how the quality and appropriateness of care for members with SHCN were addressed through various care management initiatives. The MCEs included the identification of treatment barriers and the supports needed to improve member health outcomes.
- The MCEs adopted, disseminated, and reviewed CPGs at least biennially, and included a process for soliciting feedback from contracted providers.
- The HIS for the MCEs were robust and included methods to collect, process, and report data to and from the State.

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

- For some MCEs, HSAG found that taglines in member letters and member notices did not include the same components in both the English and Spanish versions.
- For most MCEs, provider directories did not include information about the availability of accessible medical equipment and exam rooms and did not include URLs as part of the provider directory information.

- Two MCEs did not include in their policies language stating that the MCE does not "discriminate against providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Five MCEs did not include in their policies the terms "excluded, suspended, and debarred" to ensure that each does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (i.e., owning 5 percent or more of the contractor's equity) who is excluded, suspended, or otherwise debarred from participating in procurement or non-procurement activities.
- All MCEs were found to be missing language in the submitted delegation and subcontractor agreements.
- Two MCEs were unaware of the status of delegated agreements and were unable to describe the processes that addressed subcontractor performance.

To address the opportunities for improvement, HSAG recommends that the MCEs:

- Conduct a review of their written member materials to ensure that all taglines are consistent in both English and Spanish.
- Incorporate available office and exam room accommodations into the provider directory filters for people with physical disabilities.
- Amend policy language to specify that the MCE does not "discriminate against providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Revise policies to include the terms "excluded, suspended, and debarred" to ensure that each does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (i.e., owning 5 percent or more of the contractor's equity) who is excluded, suspended, or otherwise debarred from participating in procurement or non-procurement activities.
- Update the subcontractor agreements to include the federally required language.
- Maintain ultimate responsibility for subcontractor agreements through centralized oversight (e.g., by the legal department) and develop processes addressing subcontractor performance.

Validation of Network Adequacy

Time and Distance Analysis

Statewide Results

Quarterly during FY 2023–2024, HSAG validated the MCEs' self-reported compliance with minimum network requirements and provided the Department with both MCE-specific initial file review results in the NADIV dashboards and final validation results in quarterly NAV dashboards.

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

For an MCE to be compliant with the FY 2023–2024 minimum network requirements, the MCE is required to ensure that its practitioner network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level) unless otherwise specified (i.e., 90 percent access level). For example, all members residing in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two family practitioners. However, a minimum of 90 percent of members in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two general BH practitioners as is indicated by the applicable network category minimum time and distance requirements. If members reside in counties outside their MCE's contracted geographic area, the Department does not necessarily require the MCE to meet the minimum network requirements for those members. Additionally, the MCE may have alternative methods of ensuring access to care for its enrolled members, regardless of a member's county of residence (e.g., the use of telehealth).

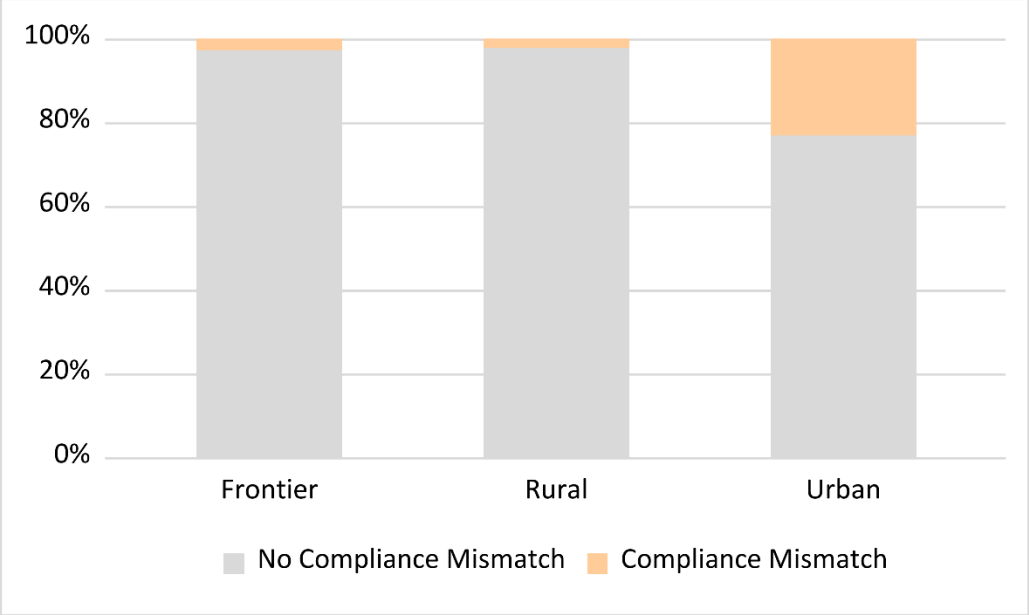
RAE Results

This section summarizes the FY 2023–2024 NAV findings specific to the seven RAEs.

Compliance Match

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

Figure 3-1—Aggregate RAE Geoaccess Compliance Validation Results for FY 2023–2024 Q2 by Urbanicity

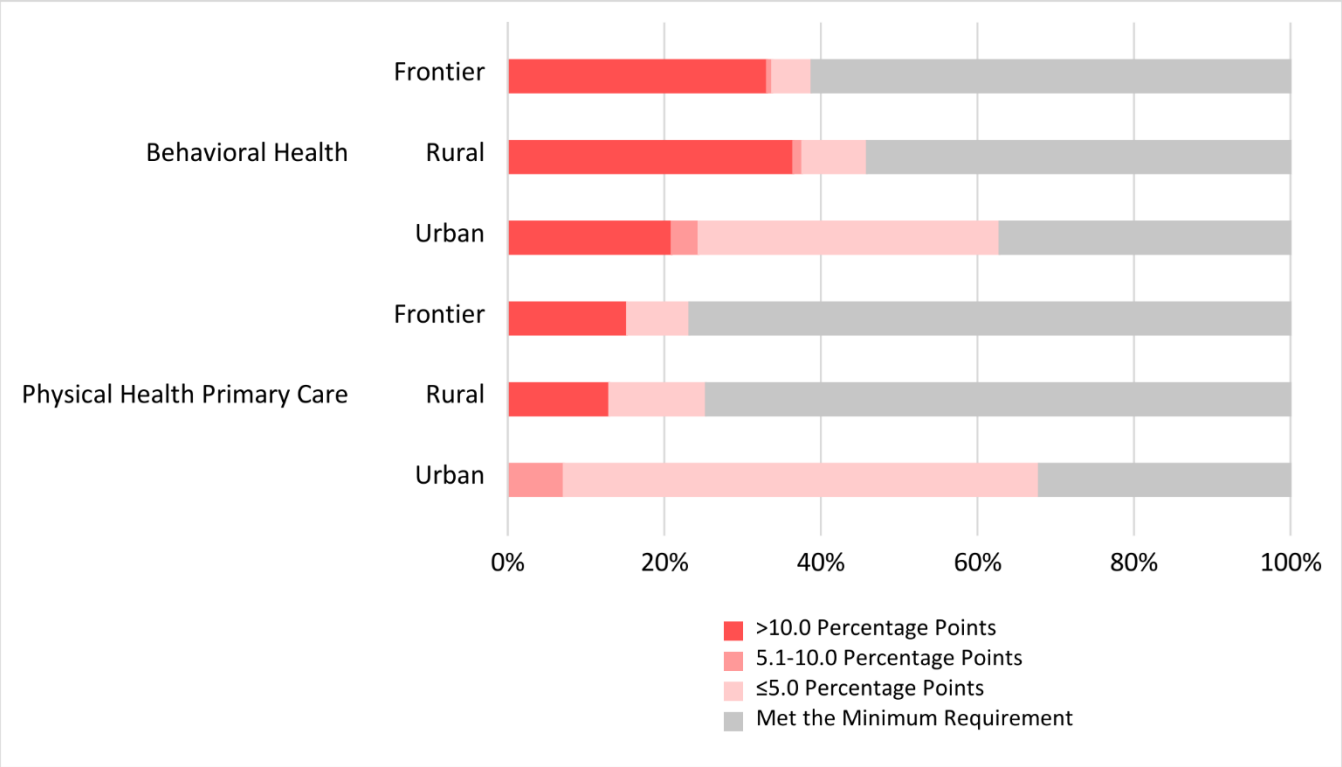


As shown in Figure 3-1, HSAG agreed with 97.7 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 98.2 percent of reported results for rural counties, and 77.4 percent of reported results for urban counties.

Access Level Assessment

Figure 3-2 displays the percentage of BH and PH primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of RAE members with access in the minimum network requirements by urbanicity for FY 2023–2024 Q2.

Figure 3-2—Percentage of Aggregate RAE BH and PH Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



Since the RAEs and DHMP are contracted to cover different Colorado counties, each combination of a minimum network requirement and county is measured separately. Not all members may reside within the RAEs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 3-2 summarizes the number of BH and PH primary care results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- Minimum time and distance BH requirements include pediatric and adult psychiatrists and other psychiatric prescribers, SUD treatment practitioners and entities, as well as psychiatric hospitals or psychiatric units in acute care hospitals. The RAEs and DHMP are required to ensure that all members have two BH practitioners or practice sites from each specified network type available within the specified time and distance requirement.

- Minimum time and distance PH primary care requirements include pediatric, adult, and family primary care practitioners, as well as gynecology and OB/GYN practitioners. The RAEs are required to ensure that all members have two primary care practitioners from each specified network type available within the specified time and distance network requirement.

Behavioral Health

HSAG assessed a total of 884 BH results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined RAEs and DHMP are contracted to serve.

- Of the aggregated frontier county BH results, 61.2 percent met the minimum network requirements (i.e., 100 percent of RAE and DHMP members with access within the designated miles and minutes). An additional 5.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.7 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 33.1 percent of the results were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county BH results, 54.1 percent met the minimum network requirements. An additional 8.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 36.5 percent of the results were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county BH results, 37.2 percent met the minimum network requirements. An additional 38.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 3.4 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 20.9 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

HSAG assessed a total of 384 PH primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined RAEs and DHMP are contracted to serve.

- Of the aggregated frontier county PH primary care results, 76.8 percent met the minimum network requirements . An additional 8.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 15.2 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county PH primary care results, 74.7 percent met the minimum network requirements. An additional 12.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 13.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

- Of the aggregated urban county PH primary care results, 32.1 percent met the minimum network requirements. An additional 60.7 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 7.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements.

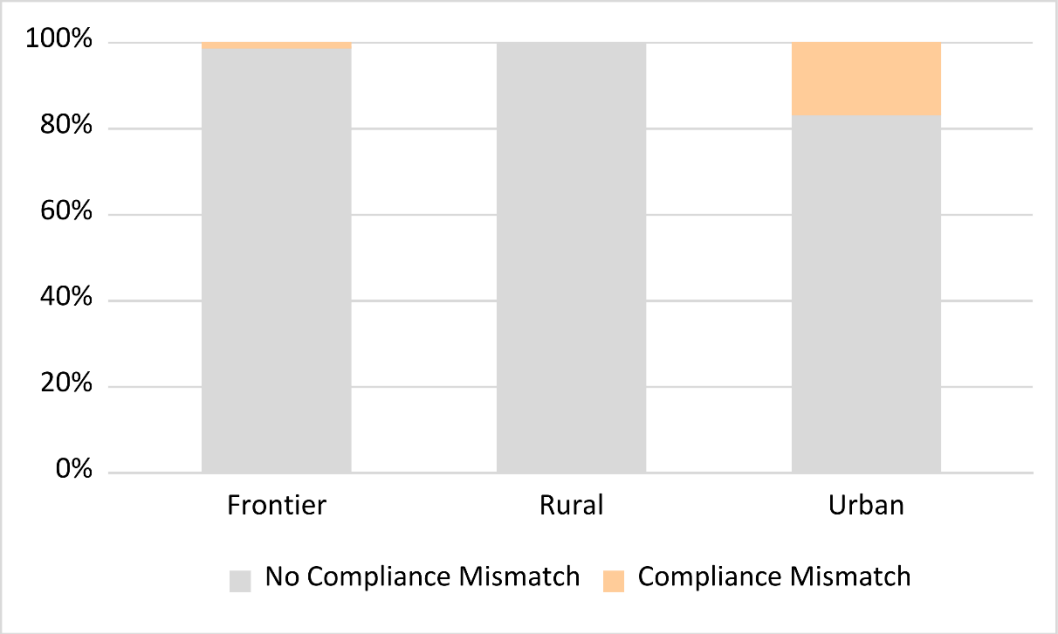
Medicaid MCO Results

This section summarizes the FY 2023–2024 NAV findings specific to the two Medicaid MCOs (DHMP and RMHP Prime). NAV results for DHMP's minimum time and distance BH requirements are also included in the RAEs' aggregated BH results because DHMP is contracted to provide BH services to its members, similar to the RAEs' contractual requirements.

Compliance Match

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

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

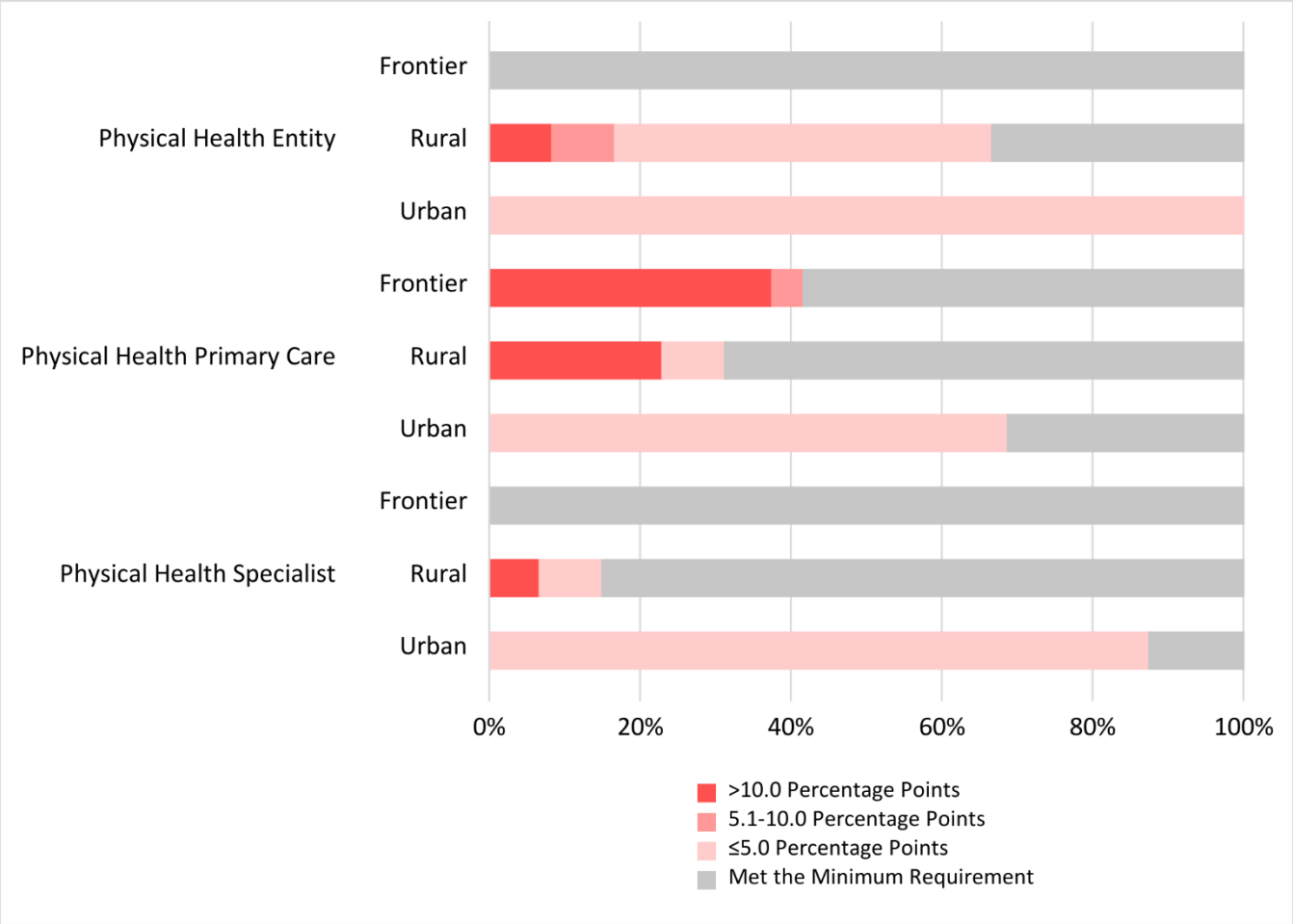


As shown in Figure 3-3, HSAG agreed with 98.9 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 100 percent of reported results for rural counties, and 83.3 percent of reported results for urban counties.

Access Level Assessment

Figure 3-4 displays the percentage of PH primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for Medicaid MCO members by urbanicity for FY 2023–2024 Q2.

Figure 3-4—Percentage of Aggregate MCO PH Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



Since the Medicaid MCOs are contracted to cover different Colorado counties (, each combination of a minimum time and distance network requirement and county is measured separately. Not all members may reside within the Medicaid MCOs' contractual minimum network requirements for one practitioner in a given network category. As such, Figure 3-4 summarizes the number of PH entity, primary care, and specialist results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

Minimum time and distance PH entity requirements include acute care hospitals and pharmacies. Medicaid MCOs are required to ensure that all members have one PH entity from each specified network type available within the specified time and distance network requirement.

Minimum time and distance PH primary care requirements include pediatric, adult, and family primary care practitioners, as well as gynecology and OB/GYN practitioners. Medicaid MCOs are required to ensure that all members have two PH primary care practitioners from each specified network type available within the specified time and distance requirement.

Minimum time and distance PH specialist requirements refer to practitioners such as cardiologists, endocrinologists, and gastroenterologists. Medicaid MCOs are required to ensure that all members have one PH specialist practitioner from each specified network type available within the minimum network requirement.

Physical Health Entities

HSAG assessed a total of 26 PH entity results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county PH entity results, 100 percent met the minimum network requirements (i.e., 100 percent of MCO members had access to PH entities within the minimum network requirements).
- Of the aggregated rural county PH entity results, 33.3 percent met the minimum network requirements. An additional 50.0 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 8.3 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 8.3 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county PH entity results, 100 percent were less than or equal to 5.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

HSAG assessed a total of 104 PH primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county PH primary care results, 58.3 percent met the minimum network requirements. An additional 4.2 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 37.5 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county PH primary care results, 68.8 percent met the minimum network requirements. An additional 8.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 22.9 percent were greater than 10.0 percentage points away from the minimum network requirements.

- Of the aggregated urban county PH primary care results, 31.3 percent met the minimum network requirements, and 68.8 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.

Physical Health Specialist

HSAG assessed a total of 260 PH specialist results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county PH specialist results, 100 percent met the minimum network requirements (i.e., 100 percent of MCO members had access to PH specialists within the minimum network requirements).
- Of the aggregated rural county PH specialist results, 85.5 percent met the minimum network requirements, 8.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 6.7 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county PH specialist results, 12.5 percent met the minimum network requirements, and 87.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.

Information Systems Capabilities Assessment

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 each of the MCEs assessed. Additionally, HSAG determined that each MCE's data collection procedures were acceptable. Fifty percent of the MCEs did not rely on an external delegated entity for network adequacy indicator reporting during the reporting period. For the MCEs that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified requiring correction within the last year.

Statewide Results

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. Table 3-9 presents the HSAG-calculated validation ratings for each of the MCEs.

Table 3-8—Validation Ratings by MCE[1]

MCE	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
DHMP	44.2%	55.8%	0%	0%
RMHP Prime	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 Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence/Significant Bias* overall. The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

Generally, the MCEs received a validation rating of *Moderate Confidence* to *High Confidence* for the network adequacy indicators. The most common issues identified were the calculation of ratios utilizing provider locations instead of unique providers and the method of calculating time and distance based on straight line distance versus driving distance.

Statewide Conclusions and Recommendations Related to Network Adequacy

Table 3-9 displays the rate of compliance matches (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) by MCE type and urbanicity. For example, HSAG agreed with 98.9 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties.

Table 3-9—Aggregate Percentage of Geoaccess Compliance Matches for FY 2023–2024 Q2 by MCE Type and Urbanicity

MCE Type	Percentage of Matching Geoaccess Compliance Results in Frontier Counties	Percentage of Matching Geoaccess Compliance Results in Rural Counties	Percentage of Matching Geoaccess Compliance Results in Urban Counties
Medicaid MCO	98.9%	100%	83.3%
RAE	97.7%	98.2%	77.4%

Based on the FY 2023–2024 time and distance and ISCA activities, HSAG identified the following strengths:

- The MCOs exhibited strength in both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements.
- The RAEs displayed strength in both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements.

- HSAG and the MCEs agreed with at least 77.4 percent of the MCEs' quarterly compliance results across all urbanicities.
- HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the assessed MCEs.
- HSAG determined that all MCEs had acceptable data collection procedures.

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

- Across all MCOs, contracted counties did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals; Gynecology, OB/GYN (PA); and SUD Treatment Facilities—ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM.
- Over 95 percent of the RAEs' contracted counties did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals and SUD Treatment Facilities—ASAM LOC 3.3.
- The most common issues identified were the calculation of ratios utilizing provider locations instead of unique providers and the method of calculating time and distance based on straight line distance versus driving distance.

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

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Explore system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Encounter Data Validation—RAE 411 Over-Read

Statewide Results

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

Table 3-10—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 3-11 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with the RAEs' (which includes DHMP's 411 results) aggregated EDV results for each of the validated data elements.

Table 3-11—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%
Place of Service	NA	96.3%	97.5%
Service Category Modifier	NA	96.3%	96.3%

Data Element	Inpatient Services (80 Over-Read Cases)	Psychotherapy Services (80 Over-Read Cases)	Residential Services (80 Over-Read Cases)
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.

Statewide Conclusions and Recommendations Related to RAE 411 Over-Read

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.

Based on the FY 2023–2024 EDV and over-read activities for the RAEs and DHMP, HSAG identified the following strengths:

- The RAEs and DHMP self-reported high overall accuracy, with 90 percent accuracy or above for three of the five inpatient services data elements, seven of the 10 psychotherapy services data elements, and all 10 of the inpatient services data elements.
- HSAG's over-read findings suggest a high level of confidence that the RAEs' and DHMP's EDV results accurately reflect their encounter data quality.
- Across all service categories, HSAG's over-read results were high, with a 98.0 percent agreement rate or higher for all five inpatient services data elements, six of the 10 psychotherapy services data elements, and two of the 10 residential services data elements. For those data elements for which HSAG did not agree with the RAEs' and DHMP's reviewers more than 98.0 percent of the time, HSAG agreed with the reviewers more than 95.0 percent of the time for all data elements.

Based on the FY 2023–2024 EDV and over-read activities for the RAEs and DHMP, HSAG identified the following opportunities for improvement:

- While the over-read results suggest confidence in the RAEs' and DHMP's EDV results, aggregated self-reported EDV results for inpatient services and psychotherapy services demonstrated a moderate

level of encounter data accuracy, with a 73.0 percent accuracy rate for the *Service End Date* data element for inpatient services and a 73.8 percent accuracy rate for the *Place of Service* data element for psychotherapy services when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends:

- The Department collaborate with the RAEs to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of the RAEs' and DHMP's provider training and/or corrective action documentation, reviewing the RAEs' and DHMP's policies and procedures for monitoring providers' BH encounter data submissions, and verifying that the RAEs and DHMP are routinely monitoring encounter data quality beyond the annual RAE 411 EDV. Additionally, given the resource-intensive nature of MRR, HSAG recommends that the RAEs and DHMP consider internal processes for ongoing encounter data monitoring and use the annual EDV study with the Department as a focused mechanism for measuring QI.

Encounter Data Validation—MCO 412 Over-Read

Statewide Results

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

Table 3-12—FY 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.

Table 3-13 shows the percentage of cases in which HSAG's reviewers agreed with the MCOs' reviewers' results (i.e., case-level and element-level accuracy rates) by service category.

Table 3-13—FY 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.

Statewide Conclusions and Recommendations Related to MCO 412 Over-Read

Based on the FY 2023–2024 EDV and over-read activities for the Medicaid MCOs, HSAG identified the following strengths:

- Results from HSAG's MCO 412 EDV over-read suggest a high level of confidence that DHMP's and RMHP Prime's independent validation findings accurately reflect the encounter data quality summarized in their service coding accuracy results.

Based on the FY 2023–2024 EDV and over-read activities for the Medicaid MCOs, HSAG identified the following opportunities for improvement:

- Both MCOs' self-reported service coding accuracy results indicate that the *Diagnosis Code* data element for professional services had a low percentage of support with a rate of 71.8 percent for DHMP and a rate of 77.7 percent for RMHP Prime.
- The *Diagnosis Code* data element also had the lowest aggregate result, 80.7 percent, among the data elements.

To address these opportunities for improvement, HSAG recommends:

- The Department collaborate with each MCO to identify best practices regarding provider education to support service coding accuracy. Identifying such practices may involve requesting and reviewing copies of each MCO's provider training and/or corrective action documentation, reviewing each MCO's policies and procedures for monitoring providers' PH encounter data submissions, and verifying that each MCO is routinely monitoring encounter data quality beyond the annual MCO 412 EDV.

CAHPS Surveys—RAEs

Statewide Results

Adult Survey

Adult Results

Table 3-14 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.

Table 3-14—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%

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
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.*

Child Survey

General Child Results

Table 3-15 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.

Table 3-15—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%

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 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.*

CCC Results

Table 3-16 shows the CCC CAHPS results for the Colorado RAE Aggregate (i.e., combined results of the seven RAEs) for FY 2023–2024.[18]

Table 3-16—FY 2023–2024 CCC Statewide CAHPS Results for Colorado RAE Aggregate

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%

[18] 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).

Measure	Colorado RAE Aggregate
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%

Statewide Conclusions and Recommendations Related to RAE CAHPS

Adult Results

The following RAEs' FY 2023–2024 CAHPS scores were statistically significantly higher than the Colorado RAE Aggregate scores:

- COA Region 3 (*Rating of Health Plan*)
- NHP Region 2 (*Getting Needed Care*)

The following RAE's FY 2023–2024 CAHPS score was statistically significantly lower than the Colorado RAE Aggregate score:

- CCHA Region 7 (*Rating of Health Plan*)

To address this low CAHPS score, HSAG recommends the Department consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.

For additional information about the CAHPS activities and results for FY 2023–2024, refer to the adult Medicaid aggregate CAHPS report on the Department's website.[19]

[19] Health Services Advisory Group, Inc. 2024 Member Experience Report, Colorado Adult Regional Accountable Entities (RAEs), September 2024. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2024_CO%20CAHPS_RAE_Adult_ExperienceRpt_Final.pdf. Accessed on: Nov 21, 2024.

General Child Results

The following RAE's FY 2023–2024 CAHPS score was statistically significantly higher than the Colorado RAE Aggregate score:

- COA Region 5 (*Rating of Health Plan*)

The following RAE's FY 2023–2024 CAHPS score was statistically significantly lower than the Colorado RAE Aggregate score:

- CCHA Region 7 (*Rating of Health Plan*)

To address this low CAHPS score, HSAG recommends the Department consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.

CCC Results

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).

For additional information about the CAHPS activities and results for FY 2023–2024, refer to the child Medicaid aggregate CAHPS report on the Department's website.[20]

[20] Health Services Advisory Group, Inc. 2024 Member Experience Report, Colorado Child Regional Accountable Entities (RAEs), September 2024. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2024_CO%20CAHPS_RAE_Child_ExperienceRpt_Final.pdf. Accessed on: Nov 21, 2024.

CAHPS Surveys—MCOs

Statewide Results

Adult Results

Table 3-17 shows the adult Medicaid CAHPS results for DHMP and RMHP Prime for FY 2023–2024.[21]

Table 3-17—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.

[21] 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.

Child Results

Table 3-20 shows the general child and CCC Medicaid CAHPS results for DHMP for FY 2023–2024.[22]

Table 3-18—FY 2023–2024 Child Medicaid CAHPS Results for DHMP

Measure	FY 2023–2024 DHMP Score	
	General Child	CCC
Rating of Health Plan	73.89%	61.86%+
Rating of All Health Care	76.42%	71.01%+
Rating of Personal Doctor	84.40%	75.00%+
Rating of Specialist Seen Most Often	71.79%+	63.64%+
Getting Needed Care	74.46%+	77.58%+
Getting Care Quickly	79.22%+	87.78%+
How Well Doctors Communicate	92.01%+	94.12%+
Customer Service	84.17%+	85.00%+
Coordination of Care	73.17%+	73.33%+
Access to Specialized Services	NA	73.41%+
FCC: Personal Doctor Who Knows Child	NA	93.69%+
Coordination of Care for Children with Chronic Conditions	NA	82.48%+
Access to Prescription Medicines	NA	81.16%+
FCC: Getting Needed Information	NA	95.71%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.
NA indicates that this measure is not applicable for the population.

Statewide Conclusions and Recommendations Related to MCO CAHPS

Adult Results

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

Child Results

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

[22] Due to a low number of respondents, HSAG is unable to present the general child and CCC Medicaid CAHPS results for RMHP Prime in this report (i.e., the results are not reportable).

Quality Improvement Plan (QUIP)

Statewide Results

Table 3-19 presents the FY 2023–2024 RAE 411 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the RAEs and DHMP (MCEs).

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

Claim Type	Time/Phase	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	DHMP
Inpatient Services	Baseline	NA	NA	NA	NA	89.8%	NA	56%	85%
	Month 1	NA	NA	NA	NA	100%	NA	100%	100%
	Month 2	NA	NA	NA	NA	100%	NA	100%	NA
	Month 3	NA	NA	NA	NA	100%	NA	100%	100%
Psychotherapy Services	Baseline	75%	NA	89%	NA	84%	83%	82%	85%
	Month 1	86%	NA	33%	NA	89%	100%	100%	92%
	Month 2	69%	NA	67%	NA	44%	100%	100%	83%
	Month 3	68%	NA	50%	NA	84%	100%	100%	67%
Residential Services	Baseline	89.8%	NA	NA	NA	NA	88%	NA	NA
	Month 1	100%	NA	NA	NA	NA	100%	NA	NA
	Month 2	100%	NA	NA	NA	NA	100%	NA	NA
	Month 3	100%	NA	NA	NA	NA	100%	NA	NA

**Red shading indicates accuracy of less than 90 percent; green shading indicates accuracy of 90 percent and higher.*
NA indicates the MCE did not have baseline scores under 90 percent; therefore, no comparisons can be made.

Table 3-20 presents the FY 2023–2024 MCO 412 QUIP cumulative average results of all claim type accuracy from baseline and the three months post intervention for the MCOs.

Table 3-20—Comparative Average Summary of Accuracy Scores for MCOs

Claim Type	Time/Phase	RMHP Prime	DHMP
Inpatient Services	Baseline	NA	89%
	Month 1	NA	100%
	Month 2	NA	90%
	Month 3	NA	100%
Outpatient Services	Baseline	87%	NA
	Month 1	88%	NA
	Month 2	100%	NA
	Month 3	100%	NA

Claim Type	Time/Phase	RMHP Prime	DHMP
Professional Services	Baseline	79%	82%
	Month 1	100%	80%
	Month 2	100%	70%
	Month 3	100%	50%
FQHC	Baseline	NA	85%
	Month 1	NA	100%
	Month 2	NA	100%
	Month 3	NA	100%

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

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

Statewide Conclusions and Recommendations Related to the QUIP

Based on the FY 2023–2024 QUIP activities, HSAG identified the following statewide strengths:

- The results indicate that each of the MCEs experienced noteworthy improvement due to the interventions implemented for this QUIP.
- For RAE 411, the most notable improvements were for two MCEs that reached 100 percent accuracy in month one and maintained 100 percent accuracy through the QUIP.
- For MCO 412, both MCOs showed improvements in most of the service categories during the three-month interventions. One MCO improved its accuracy scores for two service categories by the end of the QUIP, and the other MCO improved its accuracy scores for all 10 service categories by the end of the QUIP.
- Common interventions reported by the MCEs participating in both the 411 and 412 QUIPs included providing EDV audit feedback letters, training, and education to the selected pilot partners. In addition, most MCEs issued corrective action plans (CAPs) to the providers with results below 90 percent encounter accuracy.

Based on the FY 2023–2024 QUIP activities, HSAG identified the following statewide opportunities for improvement:

- For MCO 412, one MCO experienced some challenges with one service category decreasing throughout the three-month intervention.

- For RAE 411, the psychotherapy services category accuracy ratings were inconsistent throughout the three-month period for six MCEs.

To address these opportunities for improvement, HSAG recommends:

- The Department discuss opportunities for improvement with the MCEs with consistently low scores and develop a plan to maintain ongoing oversight of encounter data, and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Mental Health Parity Audit

Statewide Results

Table 3-21 presents the FY 2023–2024 MHP Audit statewide results for the RAEs and MCOs.

Table 3-21—MHP Audit Statewide Results for RAEs and MCOs

MCE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
RAEs—MH/SUD Services					
RMHP	1	99%	Inpatient	96%	97%v
			Outpatient	99%	
NHP	2	91%	Inpatient	89%	91%~
			Outpatient	93%	
COA	3	96%	Inpatient	95%	95%v
			Outpatient	95%	
HCI	4	92%	Inpatient	97%	96%^
			Outpatient	95%	
COA	5	94%	Inpatient	93%	95%^
			Outpatient	98%	
CCHA	6	97%	Inpatient	95%	96%v
			Outpatient	96%	
CCHA	7	92%	Inpatient	94%	95%^
			Outpatient	96%	

MCE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MCOs—MH/SUD and Medical/Surgical (M/S) Services					
DHMP		97%	Inpatient	94%	94%v
			Outpatient	95%	
RMHP Prime		100%	Inpatient	100%	100%~
			Outpatient	100%	

v *Indicates that the score decreased compared to the previous review year.*
^ *Indicates that the score increased compared to the previous review year.*
~ *Indicates that the score remained unchanged compared to the previous review year.*

Statewide Conclusions and Recommendations Related to the MHP Audit

Based on the MHP Audit results in FY 2023–2024, most (five or more) MCEs—both the RAEs and MCOs—demonstrated the following strengths statewide:

- An increase or consistent compliance scores from the previous review year.
- Used nationally recognized UR criteria such as the Milliman Clinical Guidelines (MCG), InterQual criteria, and ASAM LOC criteria.
- Followed policies and procedures regarding IRR testing, and required UM staff members to participate in IRR testing annually and earn a passing score of 80 percent or 90 percent.
- All record reviews demonstrated that all MCEs consistently documented the individual who made the ABD. Additionally, the documentation in the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so.
- Most MCEs were fully compliant in notifying the provider of the determination within the required time frame.
- Consistency between the reason for the denial determination stated in the NABDs sent to members and the reason for the determination that was documented in the UM system.
- Used a Department-approved NABD letter template, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCE in filing, access to pertinent records, and the reason for the denial. Additionally, most MCEs consistently listed all required ASAM dimensions for SUD inpatient and residential denials and how the dimensions were considered when making the denial determinations.

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

- Most MCE record review results demonstrated between one and five NABD samples that were mailed to the member outside the required time frame.
- Policies and procedures outlined the process for offering a peer-to-peer review to the requesting provider before issuing a medical necessity denial determination; however, six MCE record review results demonstrated between one and three instances in which the MCEs did not follow outlined processes.
- Consistently not demonstrating outreach to the requesting provider to request additional information before issuing a denial related to a lack of adequate documentation to determine medical necessity.

To address these opportunities for improvement, HSAG recommends:

- The Department work with the MCEs to develop and implement staff training and monitoring to ensure adherence to sending the member an NABD within the required time frame.
- The Department follow up with the MCEs that did not adhere to their internal peer-to-peer review procedures before issuing a medical necessity denial determination to the member nor thoroughly document in the record whether a peer-to-peer review was offered. Additionally, HSAG recommends that the Department review individual findings for trends and evidence of ongoing issues and consider CAPs, when appropriate.
- The Department work with the MCEs to increase outreach and consultation with the requesting provider to obtain additional information when there is a lack of adequate documentation to determine medical necessity.

QOC Grievances and Concerns Audit

Statewide Results

Table 3-22 presents the number of QOCGs each MCE reported during calendar year (CY) 2023, and the average member population for each MCE.

Table 3-22—Number of QOCG Cases by MCE

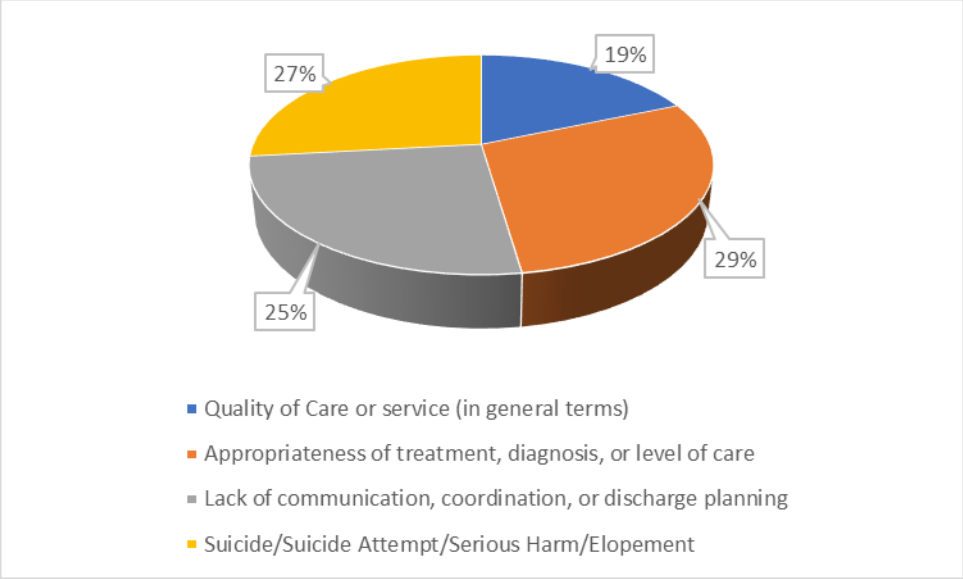
MCE	# of Investigated Cases	Average Population
RAE 1—RMHP	10	236,902
RAE 2—NHP	9	105,063
RAE 3—COA	10	358,256
RAE 4—HCI	9	147,327
RAE 5—COA	10	159,263
RAE 6—CCHA	9	186,450
RAE 7—CCHA	10	213,239
DHMP	8	101,840
RMHP Prime	10	51,824
Total	**86**	**1,560,164**

HSAG categorized the 86 cases reviewed into four broad categories of case type:

- QOC or service (in general terms)
- Appropriateness of treatment, diagnosis, or LOC
- Lack of communication, coordination, or discharge planning
- Suicide, suicide attempt, serious harm, elopement

Figure 3-5 presents the percentage of cases reported in each case type category.

Figure 3-5—Percentage of Case Types



Statewide Conclusions and Recommendations Related to the QOC Grievances and Concerns Audit

Based on the FY 2023–2024 audit activities, HSAG identified the following strengths:

- All nine MCEs used a two-factor rating scale to determine the severity level of the cases investigated. Although the scales varied among MCEs, HSAG found this practice provided the MCEs with a more detailed way to assess and understand the issues and/or actions needed.
- All nine MCEs used a two-level review, with the second review completed by a physician and/or physician committee.
- Two MCEs (RMHP and RMHP Prime) not only investigated the issue reported, but also looked for other possible issues, if any. RMHP implemented the use of letters of inquiry (LOIs) to ask specific questions that could not be answered with medical records alone. HSAG recognized this procedure as a best practice, one that allowed RMHP to evaluate additional information and aid in identifying and addressing QOCGs.
- Six of the nine MCEs' policies (RAE 1—RMHP, RAE 3—COA, RAE 5—COA, RAE 6—CCHA, RAE 7—CCHA, and RMHP Prime) documented the procedures for following up with the member to determine if immediate healthcare needs are being met, or screened the QOCG for imminent threat to patient safety, and if present, the issue is to be referred to the appropriate team for member follow-up.

Based on the FY 2023–2024 audit activities, HSAG found the following opportunities for improvement:

- Update applicable policies and procedures to address how the MCEs are to follow up to ensure that the member's immediate healthcare needs are being met, regardless of where the QOCG originates. If immediate follow-up is not indicated, the MCEs should define procedural steps regarding how other MCE departments are to reach out to members and assist with any non-emergent healthcare needs.
- Add language to the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Implement a process for notifying the Department that a QOCG has been received and document the process for submitting a QOC summary to ensure compliance with the MCE contract.

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

- Clarifying the expectations related to the contract requirement of Department notification of QOCGs and receipt of QOC summaries for each QOCG.
- Providing the MCEs with direction related to the member follow-up contract requirement.

EPSDT Services Audit

Statewide Results

Table 3-23 presents the MCE overall outcomes from the EPSDT services audit based on three components: desk review, non-utilizer record review, and post-denial record review.

Table 3-23—MCE Scores Related to EPSDT Criteria

MCE	Desk Review Score	Non-Utilizer Record Review Score	Post-Denial Record Review Score	Percentage of Criteria in Evidence
RMHP Region 1	75% ∨	75% ∨	86% ∧	66% ∨
NHP Region 2	92% ∨	63% ~	67% ∨	47% ∨
COA Region 3	92% ∨	75% ∧	77% ∧	64% ∨
HCI Region 4	92% ∨	63% ~	58% ∨	50% ∨
COA Region 5	92% ∨	69% ∨	75% ~	60% ∨
CCHA Region 6	92% ∨	75% ∨	75% ∨	64% ∨
CCHA Region 7	92% ∨	69% ∨	80% ∧	61% ∨
DHMP	92% ∨	63% ~	71% ∨	53% ∨
MCE Total Average	**90%** ∨	**69%** ∨	**74%** ∨	**58%** ∨

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

Statewide Conclusions and Recommendations Related to EPSDT Services Audit

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

- All MCEs used provider newsletters to educate and remind providers about EPSDT services.
- Three MCEs (Regions 1, 3, and 5) exhibited best practices related to internal staff member training through the use of regular chart audits and staff member feedback related to EPSDT.

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

- Out of the 120 members in the sample, 100 members received at least one annual non-utilizer outreach attempt during the review period.
- Seven of the eight MCEs conducted multiple outreach attempts to non-utilizers during the review period.

- Seven of the eight MCEs used multiple methods (e.g., mail, interactive voice response [IVR], SMS text) of non-utilizer outreach during the review period.
- Regions 3, 5, 6, and 7 demonstrated the most staggered outreach attempts.
- Regions 2 and 4 had mechanisms to track returned mail rates.

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

- All eight MCEs used the Department's NABD template during the review period.
- All eight MCEs used nationally recognized UM criteria (e.g., InterQual, MCG, ASAM).
- Five of the eight MCEs used at least one extension to ensure the reviewers had enough time and information to make a decision in the best interest of the member.
- Almost all denials related to residential treatment for members in Department of Human Services (DHS) custody were either already involved in or referred to care coordination services. Care coordination for these members often included coordinating with multiple providers/facilities, the Department, the member's family, and DHS to ensure all the needs of the member were met.
- In cases where the MCE recommended ongoing services, 81 of the 120 (or 67 percent) denial samples included documentation that the member received the recommended or other similarly appropriate services after the denial.

HSAG identified the following opportunities for improvement:

- MCE documentation did not consistently include member-specific details regarding all aspects of the expanded definition of "EPSDT MN." Additionally, the MCG included more explicit details regarding EPSDT medical necessity considerations, but neither InterQual nor the MCG contained all aspects of CMS' expanded definition of "medical necessity."
- Two MCEs did not consistently provide members with NABDs for administrative denials; therefore, the members did not receive information about appeal rights or alternative available services. Three additional MCEs sent out NABDs for administrative denials incorrectly stating that those denials were not eligible for appeal and did not include the clinical criteria used to make the denial determination.
- Care coordination documentation submitted by the MCEs showed that while several MCEs met their policy for timely outreach, cases were often closed without providing a reasonable time frame for the member, the member's family, or the caseworker to respond.
- The MCEs reported a low volume of health risk assessments reported from the Department to the MCEs, and none of the sample records included a health risk assessment. Only one MCE reported

additional efforts to complete an assessment with new members within a specified time period.

- MCE results for quarterly non-utilizer outreach reports compared to non-utilizer outreach for sample records demonstrated inconsistencies in the MCEs' self-ratings of successful outreach.

To address these opportunities for improvement, HSAG recommends:

- The Department provide and require the use of an EPSDT checklist as a best practice to ensure all aspects of the EPSDT medical necessity definition is considered when determining medical necessity.
- The MCEs update the NABDs to include all federal, State, and contractually required information (e.g., appeal rights, clinical criteria used to make the denial determination) and discuss any concerns regarding readability requirements and Department brand guidelines with the Department. The Department may also consider, as a best practice, expanding its NABD template to require the MCEs to include specific member next steps, including help with appointments and the availability of transportation. Additionally, HSAG recommends the Department work with the MCEs to standardize the definitions of "medical necessity denial" and "administrative denial."
- The Department consider defining a minimum expectation for outreach attempts, methods of outreach, and the time frame the case should remain open to allow adequate time for a response from the outreach.
- The Department explore additional new member outreach and assessment opportunities and consider requiring the MCEs to engage in additional assessment opportunities, with special focus on members with SHCN and high-risk scores.
- The Department clarify report specifications regarding what counts as "successful" for mailing, phone, IVR, text, email, and other commonly used methods of outreach.

Substance Use Disorder Utilization Management Over-Read

Statewide Results

Table 3-24 shows the number of MCE denials in the sample and the adjusted number of denials in the sample compared to the number of denials for which the MCE appropriately applied ASAM criteria.

Table 3-24—MCE Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
RAE 1	40	40	36	90%
RAE 2	26	22	15	68%
RAE 3	40	35	32	91%
RAE 4	92	83	61	73%
RAE 5	25	20	19	95%
RAE 6	42	38	34	89%
RAE 7	35	29	27	93%
DHMP	13	12	11	92%
Total	**313**	**279**[1]	**235**	**84%**

[1] *34 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 279.*

Based on the documentation provided by the MCEs, HSAG's reviewers confirmed that in 84 percent of applicable sample denials, the MCEs followed ASAM criteria.

Table 3-25 displays the number of MCE denials in the sample compared to the number of denials for which HSAG agreed with the MCE decision.

Table 3-25—MCE Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percentage of Agreement
RAE 1	40	36	90%
RAE 2	22	16	73%
RAE 3	35	34	97%
RAE 4	83	62	75%
RAE 5	20	20	100%
RAE 6	38	36	95%
RAE 7	29	28	97%
DHMP	12	11	92%
Total	**279**[1]	**243**	**87%**

[1] *34 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 279.*

HSAG's reviewers agreed with the denial decisions made by the MCEs for 87 percent of denials.

Statewide Conclusions and Recommendations Related to SUD UM Over-Read

Of the 313 sample denial determinations, 279 cases were medical necessity denials that were reviewed for adherence to ASAM criteria and agreement with denial determinations. Based on the documentation provided by the MCEs, HSAG's reviewers determined that in 84 percent of applicable sample denials, the MCEs followed the Department's guidance related to the selection and implementation of the ASAM criteria for the population and LOC requested. HSAG's reviewers agreed with the denial decisions made by the MCEs for 87 percent of denials.

HSAG identified the following strengths:

- Five of the eight MCEs (RAE 1, RAE 3, RAE 5, RAE 7, and DHMP) were high in HSAG reviewer agreement with adherence to ASAM criteria with denial decisions at 90 percent or above.
- Six of the eight MCEs (RAE 1, RAE 3, RAE 5, RAE 6, RAE 7, and DHMP) were high in HSAG reviewer agreement with denial decisions at 90 percent or above.

HSAG identified the following opportunities for improvement:

- Special Connections members (pregnant and parenting individuals up to one year postpartum) have specific *Dimensional Admissions* criteria to be considered alongside the LOC-specific criteria to

make the most appropriate determination for this population. These considerations were not applied in 15 of the 18 medical necessity cases reviewed for Special Connections members in the denial samples.

- In many instances where HSAG's reviewers disagreed with the MCE's denial determination, the MCE's UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations. While the *Dimensional Admissions* criteria are foundational to the ASAM criteria, in order to truly implement the spirit and content of the ASAM criteria, it is important to consider the individual needs of each member to "amplify the criteria with their clinical judgement, their knowledge of the patient, and their knowledge of the available resources" to ensure the most appropriate determination for each individual member.[23]
- Several of the MCEs demonstrated inconsistencies in documenting denial determinations for the ASAM LOCs 3.7 and 3.7 WM, often using the terms interchangeably. HSAG cautions the MCEs that did not clearly and consistently document these LOCs correctly as the criteria for each LOC varies greatly from the other.
- When reviewing continued stay requests, UR documentation submitted indicated that the MCEs frequently used the *Dimensional Admissions* criteria and *Risk Ratings* without the use of *Continued Service* or *Transfer/Discharge* criteria. Both the *Continued Service* and *Transfer/Discharge* criteria require a review of the member's treatment plan and progress made toward treatment goals. Although treatment plans were not submitted by the providers or requested by the MCEs in most cases reviewed, the Department's guidance allowed for equivalent documentation that shows progress toward the member's goal(s) to be considered acceptable in the place of a treatment plan.

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

- Regarding ASAM opportunities:
  - Provide guidance to the MCEs on how to incorporate the *Dimensional Considerations for Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children* in order to reduce the risk for harm to members and their dependents.
  - Encourage the MCEs to provide training to UM staff members and providers regarding the appropriate criteria to use based on the type of review, LOC, and special population considerations.
  - Encourage the MCEs to consider the member's interdimensional interactions and member-specific concerns in LOC determinations.
  - Recommend the MCEs update policies and procedures to support increased attention to detail and consistency for requests at ASAM LOCs 3.7 and 3.7 WM to ensure proper criteria are used for decision making.

[23] Mee-Lee D, Shulman GD, Fishman MJ, et al., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. American Society of Addiction Medicine; 2013: 17.

  - Require the MCEs to use treatment plans as a part of the continued service reviews to improve compliance with ASAM criteria and best practices.
- Regarding NABDs:
  - Update the Department's NABD template to include recommendations for alternative treatment locations.

Colorado's Medicaid Managed Care Quality Strategy

Overview

The Department last assessed the effectiveness of the Quality Strategy in 2021 and makes updates when significant changes occur pursuant to any new regulatory requirements under 42 CFR §438.340. The Department is working to update its Quality Strategy in FY 2024–2025. The Department's Quality Strategy review includes an evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. The Department's Quality Strategy is published to the Department's website and states that the Department takes public recommendations into consideration for updating the Quality Strategy. The Department, in alignment with the Governor's healthcare priorities, continues to focus on reducing healthcare costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive PH and BH services for the Medicaid population. The Department evaluates its effectiveness based on the following defined goals and objectives stated in the 2021 Quality Strategy Evaluation and Effectiveness Review:

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

Colorado's Strategic Pillars

In addition to the goals and objectives outlined in the Department's Quality Strategy, the Department has defined "strategic pillars" to help focus its work on the Department's mission: *Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* The strategic pillars are reflected in the quality strategy goals selected by the Department and further supported through EQR work performed.

- 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.

Furthermore, in FY 2024–2025 the Department is preparing to close out on the Accountable Care Collaborative (ACC), Phase II. The contracts with the seven RAEs will end on June 30, 2025. ACC Phase III will begin on July 1, 2025, with four newly contracted RAEs. The Department engaged in extensive stakeholder feedback sessions to assist with developing the contracts for the RAEs in ACC Phase III. The new contracts will focus heavily on performance standards that are in alignment with the Department's strategic pillars.

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

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

HSAG recommends the Department:

- Monitor the newly implemented Universal Contracting Provisions to whether the updated process is working as intended to reduce administrative burden in the public health system, seek opportunities to clarify roles for all parties, and encourage value-based payments (VBPs) that are aligned with ACC Phase III objectives.
- Continue to monitor and assess opportunities regarding preventive services through its associated performance measures, HEDIS/Core Set measures, EPSDT participation reports, and claims and utilization data.

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

HSAG recommends the Department:

- Evaluate network adequacy time and distance reports in conjunction with NAV reports and compare against available claims and utilization data to further assess network gaps and underutilization of services.
  - Consider focused VBPs and Alternative Payment Model to address network gaps, particularly regarding SUD provider availability of specific ASAM LOCs in rural and frontier counties, further supporting rural and frontier SUD providers with case management and transportation services.
- Continue its support of telemedicine by:
  - Continuing to invest in broadband support for telemedicine opportunities to improve providers' connectivity, allowing providers to benefit from health information technology/health information exchange.

  - Soliciting recommendations directly from the MCEs to target specific providers who could benefit from additional technology supports (e.g., Community Mental Health Centers [CMHCs]; provider groups; and providers who experience barriers accessing admission, discharge, and transfer [ADT] feeds and/or coordinating the transition of care process).
  - Engaging with the Office of eHealth Innovation regarding development and expansion of the Social Health Information Exchange (SHIE), specifically regional SHIE hubs to maximize funding to regional technology infrastructure and partnerships that align with the priorities of the region.

Member Health: Improve member health

HSAG recommends the Department:

- Continue its implementation of CMS Core Set measures and increase its focus on working with the MCEs with low-performing HEDIS or Core Set measure rates.
- Evaluate the impact of House Bill (HB) 22-1289, Cover all Coloradans, that expands Health First Colorado and CHP+ benefits for children and pregnant members, regardless of their immigration status.
- Encourage the MCEs to further invest in neighborhood health through community-based partnerships by supporting proven interventions that address health-related social needs (HRSN).
- Support members' health literacy through the ongoing evaluation of Department and MCE critical member materials by ensuring accuracy, completeness, readability level, and timeliness of member communications. Examples of critical member materials include new enrollee welcome information, annual reminders, and special healthcare topics in member newsletters.

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

HSAG recommends the Department:

- Further define care coordination and care management standards, referral procedures, and LOC expectations to monitor and measure outcome metrics for members with SHCN.
- Encourage the statewide adoption of additional evidence-based clinical practice guidelines and monitoring through clinical analytics.
- Consider the additional monitoring of member satisfaction across available datasets, such as CAHPS survey data, quarterly grievance reports, QOC reports, and disenrollment trends.
- Evaluate how its expanded efforts to connect children and families to coverage has impacted outcomes with a comparison of historical and present data, and evaluate for ongoing gaps in care or disparities that require additional focus for the pregnant and parenting population. Prepare to evaluate the impact of HB 22-1289 and the expansion of Health First Colorado and CHP+ benefits.
- Stipulate definitions for "grievances" and "QOC" in its contracts with the MCEs' definitions in order to work toward consistency in the members' experiences regarding the grievance, QOC, and appeals processes.

Summary and Assessment

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

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

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

- The removal of premiums, deductibles, and most copays as of July 2023.
- The implementation of QUIPs that continue to assess the accuracy of encounter data.
- The implementation of PIP topics focused on how providers collect SDOH data.
- The development of a Health Equity Plan (HEP)[24] that applies a health equity lens across all programs and initiatives. The HEP aligns with the Governor's Executive Order 175, SB 21-18, which focuses on addressing health disparities. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the Medicaid program's efforts on vaccinations, maternity and perinatal health, BH, and prevention, and aligns with CMS' Adult and Child Core Set measures. The Department provides member-level data (i.e., age, county, disability, gender, language, race, and ethnicity) to the MCEs to assist with identification of priority populations for healthcare initiatives. These efforts include ongoing work to close vaccination disparity gaps, maternity research and reporting, BH investments transformation, increasing access to prevention, and expansion of quality care. These efforts may lead to performance measure rate improvement as the work progresses.
- The promotion of the Keep Coloradans Covered campaign, which focuses on informing members of their options at the end of the public health emergency (PHE).
- The historic passing of Health Benefits for Colorado Children and Pregnant People (HB22-1289), which waives CHP+ enrollment and renewal fees, creates a lactation benefit, and creates Medicaid and CHP+ look-alike programs for children and pregnant members, regardless of immigration status.

[24] Colorado Department of Health Care Policy & Financing. Department Health Equity Plan, Fiscal Year 2022–23. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Health%20Equity%20Plan.pdf. Accessed on: Dec 10, 2024.

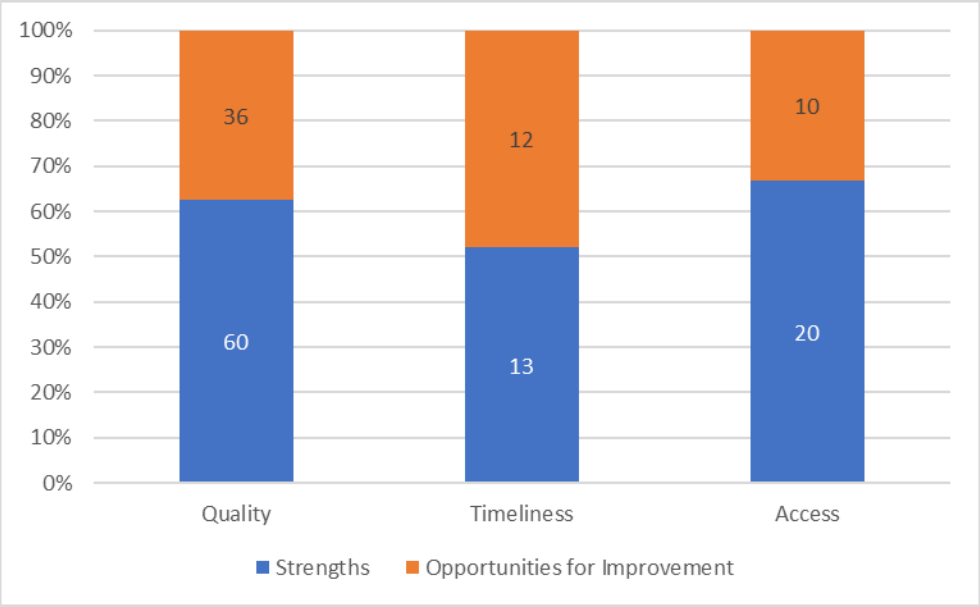
- The Department's development of robust dashboards that stratify data to provide the current or most updated disparity data and embed a health equity lens in metric deliverables and analytics. The dashboard includes quality data; CMS Core Set measure data; and Department goals and measurements by race/ethnicity, gender, language, geography, disability, and other available identifiers. The dashboard also provides additional data that can be used by the RAEs and MCOs to target interventions to improve performance measure rates. Notably, monitoring the CMS Core Set measures complements many of the Department's existing programs and initiatives, particularly the HEP.
- The use of eConsults to support PCPs and to improve the referral process. eConsults allows asynchronous electronic clinical communications between primary care medical providers (PCMPs) and specialists. These efforts are expected to expand care in the PCP office by improving access while reducing specialist "no-shows."
- The implementation of Prescriber Tool Phase II, a component of the SHIE, which helps prescribe programs or communicate care coordinators' access to health improvement programs (i.e., prenatal care; diabetes supports; or SDOH, such as Supplemental Nutrition Assistance Program [SNAP] and Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]).
- The initiatives noted above and planned for the ACC Phase III and the Alternative Payment Model 2 are strongly aligned with the Department's work related to the Division of Insurance's implementation of HB22-1325, which aims to enhance quality measures and quality reporting in a manner that is member-centered and member-informed as well as better aligned with overall systems to reduce provider administrative burden.

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

Regional Accountable Entities

Region 1—Rocky Mountain Health Plans

Figure 4-1—Number of Strengths and Opportunities for Improvement by Care Domain for RMHP*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

RMHP submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Follow-Up After Hospitalization for Mental Illness [FUH] 7-Day and 30-Day in RAE BH [Behavioral Health] Members* PIP and the nonclinical *Improving the Rate of SDOH [Social Determinants of Health] Screening for RAE Members in Region 1* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. RMHP resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 4-1 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUH 7-Day and 30-Day in RAE BH Members*

Table 4-1—2023–2024 PIP Overall Confidence Levels for the *FUH 7-Day and 30-Day in RAE BH Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
Resubmission	*Not Applicable*			*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUH 7-Day and 30-Day in RAE BH Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Improving the Rate of SDOH Screening for RAE Members in Region 1*

Table 4-2—2023–2024 PIP Overall Confidence Levels for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	50%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUH 7-Day and 30-Day in RAE BH Members*

Table 4-3 displays data for RMHP's *FUH 7-Day and 30-Day in RAE BH Members* PIP.

Table 4-3—Performance Indicator Results for the *FUH 7-Day and 30-Day in RAE BH Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 507 D: 1,283	39.52%					
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.	N: 789 D: 1,283	61.50%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP reported that the percentage of discharges for RAE members ages 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 was 39.52 percent, and the percentage of discharges who had a follow-up visit within 30 days was 61.50 percent.

Nonclinical PIP: *Improving the Rate of SDOH Screening for RAE Members in Region 1*

Table 4-4 displays data for RMHP's *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP.

Table 4-4—Performance Indicator Results for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible members in the ACC Program who had at least one billed encounter and who completed an SDOH screening in the measurement year.	N: 2,749 D: 54,361	5.06%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP reported that 5.06 percent of eligible RAE members who had at least one billed encounter were screened for SDOH during the measurement year.

Interventions

Clinical PIP: *FUH 7-Day and 30-Day in RAE BH Members*

Table 4-5 displays the barriers and interventions documented by the health plan for the *FUH 7-Day and 30-Day in RAE BH Members* PIP.

Table 4-5—Barriers and Interventions for the *FUH 7-Day and 30-Day in RAE BH Members* PIP

Barriers	Interventions
• Lack of access to timely BH visits • Lack of care coordination activities	Behavioral Health Provider Incentive Program

Nonclinical PIP: *Improving the Rate of SDOH Screening for RAE Members in Region 1*

Table 4-6 displays the barriers and interventions documented by the health plan for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP.

Table 4-6—Barriers and Interventions for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP

Barriers	Interventions
• Less engagement from providers when work is not reimbursed • No code specifically set to reimburse screening for SDOH	Provider payment for SDOH screening of members
• High rates of staff turnover require periodic re-training • SDOH screening and intervening appropriately can lead to cumbersome workflows • Meaningful storage of SDOH data and communication of information across care teams	Provider coaching on effective and efficient SDOH screening practices

RMHP: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- RMHP reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

RMHP: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. RMHP addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and RMHP received *High Confidence* for the final Module 4 submission. RMHP's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-7 shows the performance measure results for RMHP for MY 2021 through MY 2023.

Table 4-7—Performance Measure Results for RMHP

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	47.90%	53.73%	55.76%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	44.48%	50.81%	56.24%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	32.46%	35.88%	37.88%	40.14%
Follow-Up After a Positive Depression Screen	57.49%	61.40%	67.16%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	16.39%	13.17%	14.86%	36.42%

RMHP: Strengths

The following performance measure rates for MY 2023 increased from the previous year for RMHP:

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

For MY 2023, none of the measure rates exceeded the established performance measure target.

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

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

- *Engagement in Outpatient SUD Treatment*

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

To address these opportunities for improvement, HSAG recommends RMHP:

- Continue to bolster multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[25]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended RMHP:

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

Assessment of RMHP's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

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

- RMHP reported it is focusing on the measures in a Provider Cross Collaboration Committee (PCCC). This group focuses on BH measures and includes individual BH providers, along with PCMPs. RMHP reported that it has a doctorate-level integrated BH advisor who assists practices with BH workflows and implementation of best practices across RMHP's service area.
- A RAE PCMP presentation on best practices and shared its workflow for depression screening and follow-up during the April 2024 Clinical Quality Improvement (CQI) Newsroom.
- Integrating BH in many PCMPs to assist with transitions of care after hospitalizations and increase access. RMHP also reported it is growing its BH independent provider network to increase access to BH services and assist with transitions of care.

[25] Mao W, Shalaby R, Agyapong VIO. Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. *Healthcare*. 2023; 11(8):1161. Available at: https://www.mdpi.com/2227-9032/11/8/1161. Accessed on: Nov 21, 2024.

HSAG recognizes that the implementation of the PCCC, an expanded provider network and focus on integrated care, and the focus on sharing best practices are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Overall Evaluation

Table 4-8 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-8—Summary of RMHP Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%^
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%~
X. Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS)	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**53**	**1**	**0**	**0**	**98%**

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

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

~ *Indicates no change from review three years prior.*

RMHP: Trended Performance for Compliance With Regulations

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

Table 4-9—Compliance With Regulations—Trended Performance for RMHP

Standard and Applicable Review Years	RMHP Average—Previous Review	RMHP Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	90%	94%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	100%	92%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	100%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	86%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**89%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	86%	94%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**94%**	**100%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**75%**	**75%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	100%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, RMHP demonstrated consistently high-achieving scores for three out of four standards and improved its scores for two standards from the previous review cycle, demonstrating a strong understanding of the federal and State regulations. Standard IX—Subcontractual Relationships and Delegation scored 75 percent, which demonstrated a general understanding of most federal and State regulations.

RMHP: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for RMHP:

- The contract management process from procurement to execution of subcontractor agreements included monitoring via routine reporting, joint operating committees (JOCs), and dashboards.
- The QI plan included an array of topics such as performance monitoring, UM, clinical safety, programming, delegation oversight, and file review.
- RMHP described efforts to support members in rural and frontier areas, such as by providing HbA1c and colon cancer testing kits that members can use at home, which lessens the inconvenience of driving to an office for an appointment.

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

HSAG found the following opportunities for improvement:

- Three out of four written delegated agreements did not include all federally required language.

To address these opportunities for improvement, HSAG recommends RMHP:

- Revise or amend subcontractor agreements to include all required language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended RMHP:

- Provide evidence of a long-term solution for remediating and monitoring retrospective claims denials issues.
- Update language related to authorization timelines in relevant material to clarify that the time frame starts at the time of the request for service.
- Revise its policy to include the correct standards for timely access to care related to urgent services and non-urgent care visit and include the exceptions related to when well-care visits should be scheduled prior to one month.
- Modify relevant materials to remove any references that require a member to submit appeal information in writing.
- Remove language that continuation of benefits must be submitted "in writing" as it is not a requirement of the federal regulations or the State contract.

Assessment of RMHP's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, RMHP provided evidence regarding long-term updates and monitoring to ensure that member letters related to retrospective claims denials are mailed to members. RMHP updated language in relevant materials related to authorization timelines, removed any references that require a member to submit appeal information in writing, and removed language that continuation of benefits must be submitted "in writing." RMHP updated its policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits and included the exceptions related to when well-care visits should be scheduled prior to one month. HSAG recognized that updating materials and conducting ongoing monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

RMHP: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP met the minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) across all contracted counties. 
- RMHP performed strongly in the BH network category, meeting the minimum requirements for both General and Pediatric Behavioral Health, General and Pediatric Psychiatrists and other Psychiatric Prescribers, and General and Pediatric SUD Treatment Practitioner across all contracted counties. 
- While RMHP did not consistently meet the minimum time and distance requirements for the various SUD Treatment Facilities–ASAM LOC standards across counties, for ASAM LOC 3.2 WM, RMHP met the minimum network requirement in 63.3 percent of all contracted counties. For this ASAM LOC, rates of access were consistently 99 percent or greater, with the exception of four counties. 
- RMHP had established robust processes to research daily and monthly missing or incomplete data from the 834 file, which included its capture of the data on the daily fall-out reports, and manual validation and oversight by the RMHP processors for reconciliation. RMHP verified the accuracy of all data received through validation checkpoints. RMHP had strong data security, and annual testing was completed. 
- RMHP offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via My Practice Profile (MPP), Inbound Demographic Change Line, Roster Processing, and Council for Affordable Quality Healthcare (CAQH) ProView. 

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

HSAG found the following opportunities for improvement:

- RMHP did not meet the minimum time requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any contracted counties.
- RMHP consistently did not meet the minimum network requirements for any SUD Treatment Facilities–ASAM LOCs across all contracted counties. For SUD Treatment Facilities–ASAM LOC 3.7 WM, RMHP did not meet minimum network requirements in 95.5 percent of all counties. Likewise, for SUD Treatment Facilities–ASAM LOCs 3.1, 3.3., 3.5, and 3.7, RMHP did not meet the minimum network requirements in greater than 80 percent of all contracted counties.
- No ISCA-specific opportunities were identified.

To address these opportunities for improvement, HSAG recommends RMHP:

- Conduct an in-depth review of provider categories for which RMHP did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that RMHP continue to conduct an in-depth review of provider categories for which RMHP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that RMHP:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, RMHP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of RMHP's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Maintained an open network policy for all providers within its service areas who met its credentialling and quality standards. Given the rural and frontier nature of RMHP's service area, there were few new entrants into the region recently but RMHP had been able to add a small number of new providers. Most notably, RMHP recently added a nurse practitioner staff member in an endocrinology practice in Mesa County, which is a net gain in access.
- Continued to expand its pilot projects for e-consults, which provides PCP access to specialist consultations with providers outside their immediate area, and in some cases outside of the RMHP service area.
- Continued the distribution of quarterly mailings to providers. This mailing asked providers to visit the website and attest, by signing a form, if all information was correct. Or, if inaccuracies existed, to provide RMHP with the updated information.

Based on the above response, RMHP worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

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

Table 4-10—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for RMHP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	75.9%	97.8%
Diagnosis Code	70.1%	81.0%	89.8%
Place of Service	NA	73.7%	93.4%
Service Category Modifier	NA	73.0%	97.1%
Units	NA	82.5%	96.4%
Revenue Code	83.9%	NA	NA
Discharge Status	80.3%	NA	NA
Service Start Date	80.3%	83.9%	98.5%
Service End Date	83.2%	83.9%	98.5%
Population	NA	83.9%	98.5%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Duration	NA	83.2%	98.5%
Staff Requirement	NA	73.7%	97.8%

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

Table 4-11 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with RMHP's EDV results for each of the validated data elements.

Table 4-11—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for RMHP

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

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

RMHP: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP self-reported high overall accuracy for residential services, with 90.0 percent accuracy or above for nine of the 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that RMHP's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with all five inpatient services data elements, eight of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in RMHP's EDV results, RMHP's self-reported EDV results for inpatient services and psychotherapy services demonstrated a low level of encounter data accuracy. For inpatient services, accuracy rates ranged from 70.1 percent for the *Diagnosis Code* data element to 83.9 percent for the *Revenue Code* data element when compared to the corresponding medical records. For psychotherapy services, accuracy rates ranged from 73.0 percent for the *Service Category Modifier* data element to 83.9 percent for the *Service Start Date*, *Service End Date*, and *Population* data elements when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends RMHP:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended RMHP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of RMHP's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

RMHP reported implementing three initiatives to improve performance: training for reviewers, peer review of all EDV failures at weekly IRR meetings, and use of a standardized audit tool. RMHP also increased engagement with providers to improve document procurement to increase overall compliance. Finally, RMHP provided education and intervention to identified partners in residential and psychotherapy outpatient services.

Based on RMHP's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

RMHP: Adult CAHPS

Table 4-12 shows the adult CAHPS results for RMHP for FY 2021–2022 through FY 2023–2024.

Table 4-12—Adult CAHPS Results for RMHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	58.23%	54.90%	56.62%
Rating of All Health Care	59.46%	48.65%	42.86%+ ↓
Rating of Personal Doctor	71.07%	63.41%	60.58%
Rating of Specialist Seen Most Often	68.83%+	64.52%+	56.45%+
Getting Needed Care	79.47%+	79.33%	78.15%+
Getting Care Quickly	76.65%+	79.88%+	86.77%+
How Well Doctors Communicate	90.29%+	96.91%+	94.79%+
Customer Service	84.05%+	82.93%+	85.37%+
Coordination of Care	70.69%+	89.86%+	87.27%+
Advising Smokers and Tobacco Users to Quit	61.76%+	67.65%+	72.31%+
Discussing Cessation Medications	30.30%+	34.33%+	41.54%+
Discussing Cessation Strategies	39.39%+	35.82%+	35.94%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

RMHP: Strengths

The following measures' FY 2023–2024 scores for RMHP were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for RMHP were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*
- *Getting Care Quickly*

- *Customer Service*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

The following measure's FY 2023–2024 score for RMHP was statistically significantly lower than the 2023 NCQA national average:

- *Rating of All Health Care*

The following measures' FY 2023–2024 scores for RMHP were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends RMHP consider:

- Involving staff members at every level to assist in improving the member experience.
- Obtaining feedback from members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Training providers on patient-centered communication, which could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with members. Specialists could ask questions about members' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their condition and the actions they will take to monitor and manage members'

conditions in the future, as well as follow up with any concerns that members might have about their healthcare.

- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

RMHP: General Child CAHPS

Table 4-13 shows the general child CAHPS results for RMHP for FY 2021–2022 through FY 2023–2024.

Table 4-13—General Child CAHPS Results for RMHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	67.40%	71.01%	68.73%
Rating of All Health Care	64.90%	68.00%	71.07%
Rating of Personal Doctor	78.13%	71.88%	75.34%
Rating of Specialist Seen Most Often	55.17%+	66.04%+	57.14%+ ↓
Getting Needed Care	77.02%+	82.31%	83.78%
Getting Care Quickly	84.98%+	88.80%	86.91%
How Well Doctors Communicate	93.25%	95.23%	95.90%
Customer Service	84.00%+	85.71%+	86.28%+
Coordination of Care	82.81%+	86.57%+	77.61%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

RMHP: Strengths

The following measures' FY 2023–2024 scores for RMHP were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

- *How Well Doctors Communicate*

The following measures' FY 2023–2024 scores for RMHP were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measure's FY 2023–2024 score for RMHP was statistically significantly lower than the 2023 NCQA national average:

- *Rating of Specialist Seen Most Often*

The following measures' FY 2023–2024 scores for RMHP were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends RMHP consider:

- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.

- Obtaining and analyzing parents'/caretakers' of child members experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctors' offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, RMHP reported engaging in the following QI initiatives:

- The member-facing team notified provider advocates and the Value Based Contracting Review Committee (VBCRC) when a healthcare provider was not accepting new patients or were requiring applications for acceptance. Provider advocates followed up with the provider offices to investigate and address member concerns when appropriate. The care management director, a member of the VBCRC, followed up directly with members when needed. VBCRC tracked these actions to evaluate objectively if the practices were meeting the openness to Medicaid requirements outlined in their value-based contracts.
- RAE value-based contracts integrated BH components.
- During member welcome calls, customer service educated members on the importance of having a relationship with a PCP. Customer service asked whether the member had a PCP. If the member did have a PCP, customer service inquired if the member had an upcoming appointment. If the member did not have a PCP, customer service offered to help the member find one and connected the member to the office to schedule an appointment.
- During assessments with members, care coordinators asked whether members had a PCP or other provider and inquired about upcoming appointments. If the member needed assistance finding a provider, the care coordinator supplied information and assisted members in scheduling appointments.
- In the last year, a telehealth platform for members to access clinicians in real time, CirrusMD, was given more promotion in member mailers and emails, as a QR code in existing mailers, and in business cards distributed by care coordinators and external stakeholders.
- Member experience topics were included in newsletter articles, learning collaborative events, and webinar series such as training on leadership, BH skills, and care management.
- Cultural competency training was provided to providers who attended the health equity, care management, and BH skills training sessions.
- The eConsult program was expanded in Mesa County. The goal of this program was to enable primary care clinicians to send consults to specialists via a designated platform designed with the primary care patient in mind. The eConsult platform sends appropriate referrals, supports general satisfaction with providers due to reducing referrals to specialists with long wait times, empowers the primary care practice, and increases education/clinical pathways within primary care.
- A structure within the RAE value-based contracts where CAHPS scores matter was implemented, and practices were held accountable for their value-based contracts to RMHP CAHPS scores.

RMHP intends to support patient experience strategies that yielded positive CAHPS results and satisfaction with providers.

Assessment of RMHP's Approach to Addressing FY 2022–2023 CAHPS Recommendations

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

Quality Improvement Plan (QUIP)

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

Table 4-14—Summary of RMHP QUIP Outcomes

Service Categories	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Procedure Code	72%	100%	67%	60%
	Diagnosis Code	76%	87%	80%	73%
	Place of Service	67%	10%	27%	33%
	Service Category Modifier	77%	100%	67%	60%
	Units	72%	100%	60%	60%
	Service Start Date	77%	100%	87%	93%
	Service End Date	77%	100%	87%	93%
	Population	77%	100%	87%	87%
	Duration	75%	100%	60%	60%
	Staff Requirement	75%	67%	67%	60%
Residential Services	Diagnosis Code	89.8%	100%	100%	100%

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

RMHP: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP reached above 90 percent accuracy for three out of 11 data elements across two service categories with significant improvements between 10 and 16 percentage points. Most notably, the one data element for residential services reached 100 percent accuracy for month one and maintained that increase throughout the QUIP project.

- Key interventions for the QUIP consisted of providing retraction notices and educational materials that targeted the types of errors found, with specific feedback to support providers in improvement initiatives.

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

HSAG found the following opportunities for improvement:

- RMHP reported inaccurate documentation for the appropriate place of service, appropriate provider, and staff signature requirements, which resulted in low accuracy results by month three.
- Most data elements improved in month one but declined by month two.
- For the psychotherapy services category, eight out of 10 data elements showed little to no improvement by the end of the QUIP.

To address these opportunities for improvement, HSAG recommends RMHP:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that RMHP maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Assessment of RMHP's Approach to Addressing FY 2022–2023 QUIP Recommendations

RMHP reported that it utilizes the monitoring and audit program to perform quarterly audits to educate and train providers. RMHP has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that timely and consistent auditing, paired with feedback, is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-15 displays the MHP Audit compliance scores for RMHP for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-15—FY 2023–2024 MHP Audit Score for RMHP

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
RMHP	1	99%	Inpatient	96%	97%v
			Outpatient	99%	

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

RMHP: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP used nationally recognized UR criteria (MCG or ASAM) for all records reviewed.
- RMHP followed policies and procedures regarding IRR testing and required UM staff members to pass IRR testing annually, including a minimum passing score of 80 percent. All participating staff members passed with a minimum score of 80 percent or better.
- RMHP followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services.
- RMHP staff members reported an increase in average length of stay for SUD low-intensity (ASAM Level 3.1) and high-intensity residential (ASAM Level 3.5) LOCs, and in an effort to decrease provider administrative burden and improve member care, RMHP extended initial authorization from 14 days to 30 days beginning in April 2023.
- For all 10 inpatient and 10 outpatient records reviewed, RMHP made the denial determinations within the required time frame, and providers were notified of the denial determinations by telephone, secure email, and/or a copy of the NABD.
- In all cases reviewed, the denial determination was made by a qualified clinician and contained evidence that a peer-to-peer review was offered to the requesting provider, if applicable.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system.
- RMHP's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RMHP in filing an appeal, and access to pertinent records.

Additionally, the NABDs included member-specific information and contact information for providers in the area for alternative treatments/services, if applicable.

- During the MHP interview, RMHP staff members reported enhancing documentation of outreach to the member after discharge from ASAM LOC treatments/services so that case managers could better serve the member. RMHP staff members also reported conducting case management meetings while members were in residential/inpatient treatment LOC to increase engagement in case management services, and having dedicated SUD case managers and peer support specialists who follow up with the member post-discharge.

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

HSAG found the following opportunities for improvement:

- One record reviewed demonstrated the member did not receive an NABD and was only copied on the provider notice letter, which did not include all required content for an NABD.
- One request for service was denied due to lack of documentation to determine medical necessity, and the record reviewed contained no evidence of RMHP reaching out to the requesting provider for additional information.
- Two NABDs reviewed contained medical jargon/terminology.

To address these opportunities for improvement, HSAG recommends RMHP:

- Implement ongoing staff member training to ensure the member is issued an NABD, including when issuing a retrospective medical necessity denial.
- Enhance monitoring procedures to ensure that additional outreach to the requesting provider occurs when adequate documentation is not received.
- As a best practice, include a plain language explanation next to any medical terminology.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended RMHP:

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

Assessment of RMHP's Approach to Addressing FY 2022–2023 MHP Recommendations

RMHP reported addressing HSAG's recommendations by:

- Implementing a standardized checklist for every NABD that is issued. The standardized checklist is used by RMHP staff members to ensure that the criteria used are explained within the NABD.
- Revising the NABD to include and explicitly specify both the denial decision date by RMHP and the date(s) of service that are denied within the NABD template.

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

QOC Grievances and Concerns Audit

In CY 2023, RMHP investigated 193 potential QOCG cases. RMHP's average membership in CY 2023 was 236,902, with 199,534 members enrolled as of December 31, 2023. Of the 10 QOCG cases submitted by RMHP, eight cases were substantiated.

RMHP: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP policies described a process in which the clinical reviewer, medical director, and the regional peer review committee investigate, analyze, track, trend, and resolve QOCGs. The record reviews showed that RMHP followed the process outlined in its policies and procedures.
- When investigating a potential QOCG, RMHP not only investigates the issue reported, but also other issues identified within the member record, if any. RMHP then sends the provider/facility an LOI with specific questions to ensure that the RMHP staff member investigating understands the situation from all parties involved. Staff members stated that the additional information helps RMHP make the final determination and whether an improvement action plan (IAP) is needed for the provider/facility.
- RMHP's policy requires the medical director to review any potential *Level 2* or *Level 3* cases. RMHP staff members explained that, due to an increase in volume and severity of QOCGs from a large provider, they have been sending every BH potential QOCG to the medical director for review. Staff members stated that this process is a temporary change made to provide support, training, and oversight for providers.
- Two of the sample cases reviewed were submitted by a member. In both cases, the member received an acknowledgement letter within two days and a resolution letter within 15 days of RMHP receiving the QOCG.

- RMHP provides the Department with a monthly QOCG closed cases report, which fulfills its contract requirement of notifying the Department of receipt of a QOCG and sending a QOC summary.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- The *Quality of Care Investigation, Improvement Action Plan and Disciplinary Actions* policy described how all QOCGs are first screened for any imminent threat to patient safety. If it is determined that an imminent threat to patient safety is present, the issue is to be referred to Quality Intervention Services for follow-up. Although the policy described how QOCGs are screened for imminent threat to patient safety, the policy did not discuss how RMHP is to follow up with the member to determine if the member's immediate healthcare needs are being met, even if they do not meet criteria for imminent threat to patient safety. RMHP confirmed that member follow-up is completed by the customer service agent (CSA) for member grievances only, and QOCCs submitted by internal staff members do not receive member communication.
- The policies and procedures did not describe case-specific reporting to the Department when RMHP receives a potential QOCG or submits a QOC summary to the Department as detailed in the MCE contract.
- RMHP member materials did not distinguish between a member grievance and a QOCG.

To address these opportunities, HSAG recommends that RMHP:

- Update its applicable policies and procedures to include member outreach for all potential QOCGs to ensure that the member's immediate healthcare needs are being met as required in the MCE contract.
- Update its applicable policies and procedures to address the process for notifying the Department when a QOCG has been received and the process for submitting a QOC summary to ensure compliance with the MCE contract.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023.

EPSDT Audit

Table 4-16 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-16—FY 2023–2024 EPSDT Audit Findings for RMHP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	83%	67%	75%
Non-Utilizer Record Review	100%	50%	75%
Post-Denial Record Review	92%	80%	86%

RMHP: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP's adherence to its EPSDT policy and provider trainings was evidenced through distribution of an EPSDT Provider Guidebook, annual provider notice, the provider newsletter, Provider Insider Plus, as well as webinars and trainings twice a year. RMHP tracked registered attendees and followed up with post-event surveys to track participants' understanding of the materials. 
- RMHP used an EPSDT checklist for each UM denial review and also performed an annual EPSDT quality audit, which staff members described to include all components of the American Academy of Pediatrics (AAP) Bright Futures Guidelines and assisted in reviewing for possible underutilization for both EPSDT and members with SHCN. 
- Documented procedures included additional considerations and outreach opportunities for children involved with child welfare. 
- One applicable case demonstrated that RMHP covered treatment regardless of co-occurring conditions until RMHP believed the LOC being received was no longer medically necessary. 
- RMHP's NABDs included easy-to-understand explanations and member-friendly language. Eight NABDs included member-specific EPSDT information, and the remaining seven NABDs included generic EPSDT information. All 15 NABDs included next steps for the member, such as scheduling an appointment with a provider or following up with care coordination. Ten NABDs included details regarding assistance in identifying or scheduling a follow-up appointment and, in some of the letters, the NABD included contact information for specific providers who offered the alternative LOC recommended. Additionally, an EPSDT policy stated that RMHP will include an EPSDT informational flyer in the denial letter, which was recognized as a best practice. 

- An RMHP job aid emphasized that a peer-to-peer review must occur with the requesting provider or someone who has direct contact with the member.
- All 15 sample cases reviewed either referred the member to care coordination or the member was already involved in care coordination. Additionally, RMHP's care coordination letter titled "Sorry We Missed You" included EPSDT information and the EPSDT informational flyer.
- Each member in the RMHP non-utilizer sample who had not utilized services received at least one outreach attempt during the review period. Most members received an EPSDT mailed letter and flyer that contained comprehensive lists of EPSDT services available to the member that included transportation assistance, care management, and mental health services, and the availability of assistance from RMHP to assist the member in finding a primary care medical provider, dentist, and other EPSDT resources available to the member.

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

HSAG found the following opportunities for improvement:

- Not all cases reviewed adequately documented that RMHP considered the full EPSDT definition of "medical necessity" during the UM process.
- RMHP team meeting notes and informal job aids for BH and SUD contained conflicting information regarding EPSDT and conflicted with federal and State regulations as well as RMHP's own policies.
- During the interview, RMHP staff shared that they do not apply EPSDT considerations to medical necessity denials until after an appeal has been filed to ensure all other avenues for approval are exhausted.
- Within two RMHP policies, the definition of "ABD" differed from the federal and State definition. Additionally, RMHP's job aids for BH and SUD denials included incorrect time frames for mailing the NABD letters to the member.

To address these opportunities for improvement, HSAG recommends RMHP:

- Strengthen its UM procedures to ensure the full EPSDT definition of "medical necessity" is considered prior to the secondary reviewer making a denial determination and to clarify that EPSDT applies equally to both medical necessity and administrative authorization procedures.
- Review meeting minutes and job aids for clarity prior to distributing information internally and externally.
- Update policies and procedures to include consideration of EPSDT during the initial medical necessity review, rather than after the denial has been made or after the member completes the appeal process.

- Revise RMHP's definition of an "ABD" in both policies, as it currently differs from the federal and State definition. Additionally, HSAG recommends aligning the job aids to the formal policies, which include correct time frames.

During the FY 2023–2024 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- Multiple cases reviewed and demonstrated the member was referred to care coordination upon the denial of services were closed due to the care coordinator being unable to reach the member, member's family, or case worker.
- RMHP used various methods of communication for annual non-utilizer outreach including mail. RMHP staff members confirmed during the interview that RMHP does not track returned mail correspondence.

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

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended RMHP:

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

Assessment of RMHP's Approach to Addressing FY 2022–2023 EPSDT Recommendations

RMHP still has the opportunity to address HSAG's recommendation of engaging in additional discussions with the Department regarding any updates to tracking completion rates for outreach efforts. However, RMHP reported adding additional information to all NABDs to provide the member information regarding the availability of care management and provided the member with contact information for RMHP to assist with setting up transportation and scheduling appointments. Additionally, RMHP reported implementing a rigorous audit process to ensure the accuracy and completeness of all denial cases and results are shared with RMHP staff members monthly to ensure continuous improvement. RMHP's response to the recommendations is likely to improve member communication and awareness. RMHP should continue to address the recommendations by HSAG to improve overall UM processes and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-17 displays the percentage of cases reviewed that HSAG's reviewers determined adhered to ASAM criteria.

Table 4-17—RMHP Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
RMHP	40	40	36	90%

Table 4-18 presents the number of cases in the sample that HSAG reviewed for RMHP and the percentage of cases in which HSAG's reviewers agreed with RMHP's denial determination.

Table 4-18—RMHP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
RMHP	40	40	36	90%

RMHP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP consistently documented multiple outreaches to the requesting provider to conduct peer-to-peer reviews and obtain additional documentation, when necessary. HSAG recognizes this as a best practice.
- Out of the 40 sample denial cases, 19 indicated an alternative LOC was approved. RMHP was the most consistent MCE to document approved alternative LOCs. HSAG recognizes this as a best practice.
- RMHP included detailed notes to document when the NABDs were mailed, and HSAG recognizes this as a best practice.

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

HSAG found the following opportunities for improvement:

- RMHP's sample included one Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible member, but the chart documentation did not indicate additional EPSDT considerations during UR.
- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making denial determinations.
- The RMHP Behavioral Health Provider Manual did not include 3.2WM as a covered LOC. The ASAM Clinical Documentation Tool and Reference Guide provided for review explicitly stated that 3.2WM was not a covered LOC.
- RMHP demonstrated inconsistencies in documenting denial determinations for 3.7 and 3.7WM LOCs, often using the terms interchangeably.

To address these opportunities for improvement, HSAG recommends RMHP:

- Include specific documentation in UM system notes to demonstrate the review of EPSDT criteria for eligible members.
- Host training for providers and UM reviewers regarding the importance of considering the member's interdimensional interactions and co-occurring problems during the review process.
- Update policies, procedures, and the provider manual to include all covered LOCs.
- Enhance communication with providers and UM staff members regarding increased attention to detail and consistency for requests at 3.7 and 3.7WM LOCs to ensure proper criteria are used for decision making.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that RMHP:

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

Assessment of RMHP's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

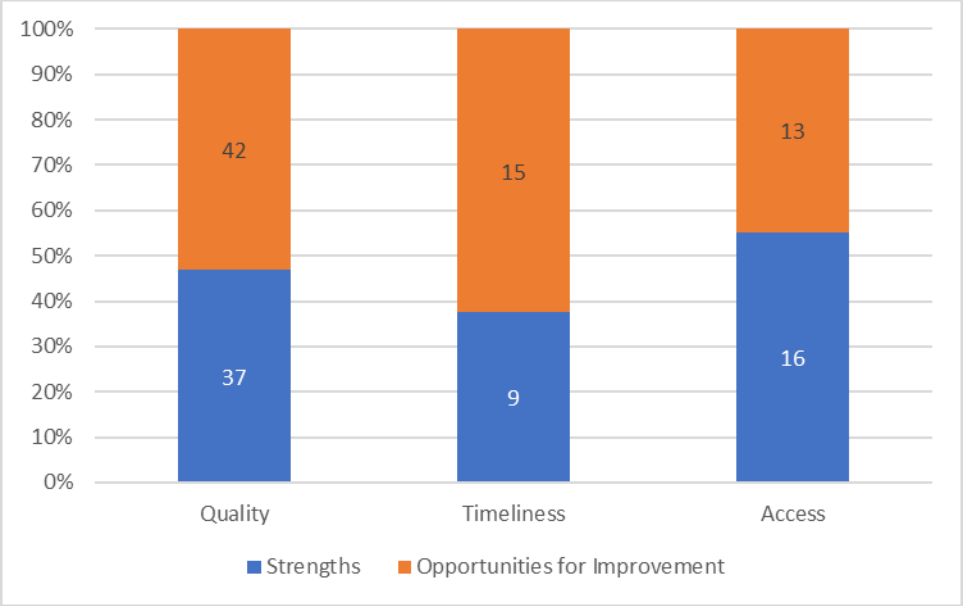
RMHP reported addressing HSAG's recommendations by:

- Implementing a comprehensive system to enhance the readability and consistency of its denial notices. Specifically, RMHP UM reported that it established a uniform format for different types of requests and ensured that all denial letters are written in a member-friendly style.
- Utilizing a standardized checklist for every denial letter that is issued. RMHP described that an additional item was added to this checklist to ensure that all letters are written in a clear and concise manner and utilizing language that is easily comprehensible to the general public.

HSAG anticipates RMHP's responses to the recommendations are likely to improve overall processes and communication between RMHP and the members it serves. RMHP should continue addressing the recommendations made by HSAG for continuous improvement.

Region 2—Northeast Health Partners

Figure 4-2—Number of Strengths and Opportunities for Improvement by Care Domain for NHP*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

NHP submitted two PIPs for the 2023–2024 validation cycle. The clinical *Follow-Up After Emergency Department Visits for Substance Use [FUA]: Ages 13 and Older* PIP and the nonclinical *Screening for Social Determinants of Health (SDOH)* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. NHP resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 4-19 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUA: Ages 13 and Older*

Table 4-19—2023–2024 PIP Overall Confidence Levels for the *FUA: Ages 13 and Older* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	88%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUA: Ages 13 and Older* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. NHP received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Screening for SDOH*

Table 4-20—2023–2024 PIP Overall Confidence Levels for the *Screening for SDOH* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
Resubmission	*Not Applicable*			*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Screening for SDOH* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. NHP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUA: Ages 13 and Older*

Table 4-21 displays data for NHP's *FUA: Ages 13 and Older* PIP.

Table 4-21—Performance Indicator Results for the *FUA: Ages 13 and Older* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of ED visits for members ages 13 years and older with a principal diagnosis of	N: 306	26.8%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.	D: 1,142						

N–Numerator D–Denominator

For the baseline measurement period, NHP reported that 26.8 percent of members ages 13 years and older who visited the ED with a principal diagnosis of SUD or other diagnosis of drug overdose had a follow-up visit within seven days.

Nonclinical PIP: *Screening for SDOH*

Table 4-22 displays data for NHP's *Screening for SDOH* PIP.

Table 4-22—Performance Indicator Results for the *Screening for SDOH* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of members with at least one BH visit who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	N: 0	0%					
	D: 20,498						

N–Numerator D–Denominator

For the baseline measurement period, NHP reported that 0 percent of members with at least one BH visit were screened for the four SDOH domains.

Interventions

Clinical PIP: *FUA: Ages 13 and Older*

Table 4-23 displays the barriers and interventions documented by the health plan for the *FUA: Ages 13 and Older* PIP.

Table 4-23—Barriers and Interventions for the *FUA: Ages 13 and Older* PIP

Barriers	Interventions
Unclear understanding of services, codes, and timeliness required to meet the measure.	Provider and case management education.

Nonclinical PIP: *Screening for SDOH*

Table 4-24 displays the barriers and interventions documented by the health plan for the *Screening for SDOH* PIP.

Table 4-24—Barriers and Interventions for the *Screening for SDOH* PIP

Barriers	Interventions
No standardized process to identify who needs to be screened, the frequency of screening members, questions to address SDOH, or method to track screening statistics.	Standardized screening process.

NHP: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for NHP:

- NHP followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- NHP reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

NHP: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. NHP addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and NHP received *High Confidence* for the final Module 4 submission. NHP's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-25 shows the performance measure results for NHP for MY 2021 through MY 2023.

Table 4-25—Performance Measure Results for NHP

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	50.80%	54.11%	59.54%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	50.07%	49.78%	51.08%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	29.64%	28.41%	35.65%	40.14%
Follow-Up After a Positive Depression Screen	87.09%	83.84%	83.84%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	18.60%	14.57%	14.38%	36.42%

NHP: Strengths

The following performance measure rates for MY 2023 increased from the previous year for NHP:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*

Additionally, the following performance measure rate for MY 2023 exceeded the performance measure target:

- *Engagement in Outpatient SUD Treatment*

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

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

- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*

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

To address these opportunities for improvement, HSAG recommends NHP:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[26]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended NHP:

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

Assessment of NHP's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

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

- A partnership with Carelon's Data, Analytics, & Reporting team to leverage any opportunity regarding completeness and timeliness of data on the performance measures that NHP calculates performance on during the year (i.e., BHIP measures). Previous performance measure dashboards reported scores on these measures following a full 90-day claim lag period from the end of the reference month. The analysis of claims and encounters revealed that greater than 96 percent of claims and encounters are received within 30 days of service. Following consultation with clinical leadership and quality subject matter experts, the performance measure dashboards were amended to report performance at the earliest possible opportunity (i.e., 30-day claim lag).
- Enhanced its work with Eastern Plains providers to notify NHP of members who meet a hospital's measure criteria. For these hospitals, NHP created an internal secure system called the "HTP Hospital Provider Portal" for staff to use to send notifications. NHP provided multiple training sessions to hospital managers on how to navigate and use the system, and ensured those who wished to utilize it were connected prior to the Department's reporting start date of October 1, 2023. NHP receives a notification of each submission via email, improving timeliness of connecting members to care coordination.

[26] Ibid.

HSAG recognizes that NHP's enhancement of its dashboard to provide more actionable data and its work with hospitals to receive notifications of members who need care coordination are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

NHP Overall Evaluation

Table 4-26 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-26—Summary of NHP Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	12	4	0	0	75%v
IX. Subcontractual Relationships and Delegation	4	4	2	2	0	0	50%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**48**	**6**	**0**	**0**	**89%**

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

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

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

~ *Indicates no change from review three years prior.*

NHP: Trended Performance for Compliance With Regulations

Table 4-27 presents, for all standards, the overall percentage of compliance score for NHP for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-27—Compliance With Regulations—Trended Performance for NHP

Standard and Applicable Review Years	NHP Average—Previous Review	NHP Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	97%	91%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	94%	93%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	91%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**86%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	77%	91%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**94%**	**75%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	94%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**75%**	**50%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	100%	86%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, NHP demonstrated high-achieving scores for two out of the four standards. Most notably, Standard V—Member Information Requirements increased by 14 percentage points to 100 percent compliance, demonstrating a strong understanding of related federal and State regulations. Scores for two standards, Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation, declined from the previous review cycle with the most notable decrease of 25 percentage points for Standard IX—Subcontractual Relationships and Delegation.

NHP: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for NHP:

- NHP provided health education via text, email, and IVR modalities designed to increase member understanding about the RAE's benefits and requirements.

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

HSAG found the following opportunities for improvement:

- Carelon's credentialing policy did not include required language indicating that it does not discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- Policies and procedures did not state that Carelon would not knowingly employ any staff members who are "suspended" from federal participation.
- The provider agreement did not include required language stating that NHP does not prohibit or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member.
- NHP did not provide evidence that it maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance.
- NHP did not indicate that the oversight of its administrative service organization (ASO), Carelon, included annual monitoring of all delegated activities or assessing Carelon against specific performance standards to ensure compliance with delegated requirements.
- Written subcontractor delegation agreements did not include all federally required language.

To address these opportunities for improvement, HSAG recommends NHP:

- Determine what accommodation for people with disabilities may be included in a BH setting and incorporate these accommodations into the provider directory filters.
- Revise its policies to include language that states that Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Update its policies to include the terms "excluded," "suspended," and "debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or

owner (i.e., an individual owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities.

- Modify the provider agreement to include language stating that NHP does not prohibit, or otherwise restrict, healthcare professionals acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient.
- Strengthen documentation of internal NHP compliance oversight and monitoring procedures.
- Conduct ongoing monitoring of Carelon to ensure that it meets these benchmarks and expectations and align its delegation agreement with its policies and procedures.
- Revise or amend the written agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended NHP:

- Enhance its procedures and monitoring to ensure that all denial decisions are made within time frame requirements.
- Improve its procedures and monitoring to ensure that all member notices are sent within time frame requirements.
- Correct timely appointment standards in the PCP Practitioner Agreement.
- Update member letters that were missing required content.
- Revise documents that stated that members must follow a verbal appeal request with a written request.
- Update the appeal policy to include that the coordinator will make reasonable efforts to notify the member of the delay if the delay is in the member's best interest.

Assessment of NHP's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, NHP updated its policy and other supporting documentation to clarify that the denial decision time frame is based on the date of the service request until the deadline. NHP corrected the timely appointment standards in the PCP Practitioner Agreement. NHP enhanced ongoing monitoring and oversight of its delegates to ensure member letters include the required content. The requirement that the member must follow a verbal appeal request with a written request was removed from documents. In addition, staff members were made aware of updated documentation. Lastly, NHP revised its appeal policy to add that the coordinator will make reasonable efforts to notify the member of the extension if the extension is in the member's best interest. HSAG recognizes that updating supporting documentation with corrected time frames, member notice procedures, member letter content, and ongoing monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

NHP: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for NHP:

- NHP met all minimum network requirements for both General and Pediatric Behavioral Health, as well as both General and Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.
- NHP met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 90 percent of contracted counties. In the two counties where the plan did not meet the minimum network requirements for both General and Pediatric SUD Treatment Practitioner, access was 99.7 percent.
- NHP met the minimum network requirements for Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in 90 percent of contracted counties, and for Adult Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) in 80 percent of all contracted counties. For these provider types, where NHP did not meet the standard, access was 98 percent or greater.
- NHP had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and annual provider directory attestation requirement, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.
- NHP had established a robust process to maintain data accuracy by frequently performing internal audits of a representative sample of updated member and provider records, wherein audits were conducted at a 100 percent rate for new employees and reduced as accuracy goals were met.

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

HSAG found the following opportunities for improvement:

- NHP did not meet the minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.1, 3.2 WM, and 3.3 in any contracted counties, nor did NHP meet the minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.7 and 3.7 WM in 90 percent of contracted counties.
- NHP did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in 80 percent of contracted counties.
- While NHP performed fairly well for the Adult, Pediatric, and Family Primary Care Practitioners (MD, DO, NP, CNS) provider categories, the plan did not consistently meet minimum network requirements for each Adult, Pediatric, and Family Primary Care Practitioners (PA) across

contracted counties. Results varied by urbanicity, with urban and rural counties collectively demonstrating 98 percent or greater access to these provider types. NHP struggled particularly in frontier counties, with access in counties where the plan did not meet the minimum network standards for Adult, Pediatric, and Family Primary Care Practitioners (PA) ranging from 32.2 percent to 44.2 percent.

- NHP used the daily and monthly 834 files for member demographic data, but up to 5 percent of members on the enrollment files did not have a physical address on the file.

To address these opportunities for improvement, HSAG recommends NHP:

- Conduct an in-depth review of provider categories for which NHP did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Inquire with the Department regarding whether it should pursue other sources of address information for its members to ensure completeness of its member data used for network adequacy reporting.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that NHP continue to conduct an in-depth review of provider categories for which NHP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that NHP:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, NHP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the NHP data that could not be located in the online provider directory.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of NHP's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Continued to work on surveying the network to ensure any eligible SUD provider/facility will be added to the network if available. This continues to be an issue in the market as there are areas where SUD facilities are not available. NHP focused on continuing to contract with providers or amend provider agreements to add High Intensity Outpatient services to the network through the High Intensity Outpatient (HIOP) expansion effort.
- Performed ongoing coordination of care with members where a SUD facility is not available and potentially refers them to another location. NHP stated it also offers a single case agreement if necessary. NHP also offers telehealth services and is adding telehealth providers throughout the fiscal year to ensure access for all members.

Based on the above response, NHP worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-28 presents NHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-28—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for NHP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	93.4%	100.0%
Diagnosis Code	89.8%	98.5%	97.1%
Place of Service	NA	67.2%	97.8%
Service Category Modifier	NA	97.1%	100.0%
Units	NA	99.3%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	95.6%	NA	NA
Service Start Date	100.0%	98.5%	100.0%
Service End Date	90.5%	98.5%	100.0%
Population	NA	99.3%	100.0%
Duration	NA	91.2%	100.0%
Staff Requirement	NA	99.3%	100.0%

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

Table 4-29 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with NHP's EDV results for each of the validated data elements.

Table 4-29—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for NHP

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

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

NHP: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for NHP:

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

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in NHP's EDV results, NHP's self-reported EDV results for psychotherapy services demonstrated a low level of encounter data accuracy, with a 67.2 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends NHP:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended NHP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of NHP's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

NHP reported implementing training for providers on the RAE 411 audit, service categories, and common areas of concern. Additionally, NHP reported performing additional checks and balances to ensure accuracy of received data.

Based on NHP's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

NHP: Adult CAHPS

Table 4-30 shows the adult CAHPS results for NHP for FY 2021–2022 through FY 2023–2024.

Table 4-30—Adult CAHPS Results for NHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	57.58%+	58.91%	59.82%
Rating of All Health Care	52.94%+	45.45%+	58.97%+
Rating of Personal Doctor	73.33%+	68.48%+	72.94%+
Rating of Specialist Seen Most Often	72.34%+	63.27%+	66.00%+
Getting Needed Care	81.68%+	83.94%+	89.66%+ ↑
Getting Care Quickly	80.63%+	80.25%+	85.04%+
How Well Doctors Communicate	92.80%+	91.02%+	94.59%+
Customer Service	82.69%+	94.83%+	94.29%+
Coordination of Care	95.35%+	78.95%+	87.18%+
Advising Smokers and Tobacco Users to Quit	53.85%+	57.63%+	60.00%+ ↓
Discussing Cessation Medications	30.77%+	33.90%+	40.00%+
Discussing Cessation Strategies	30.77%+	30.51%+	36.23%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

NHP: Strengths

The following measure's FY 2023–2024 score for NHP was statistically significantly higher than the 2023 NCQA national average:

- *Getting Needed Care*
- The FY 2023–2024 scores for NHP were higher, although not statistically significantly, than the FY 2022–2023 scores for every measure except one.

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

The following measure's FY 2023–2024 score for NHP was statistically significantly lower than the 2023 NCQA national average:

- *Advising Smokers and Tobacco Users to Quit*

The following measure's FY 2023–2024 score for NHP was lower, although not statistically significantly, than the FY 2022–2023 score:

- *Customer Service*

To address these low CAHPS scores, HSAG recommends NHP consider:

- Involving staff members at every level to assist in improving the member experience.
- Providing internal training sessions and sending out newsletters designed to educate providers on the importance of guiding and advising smokers and tobacco users to quit. The training could emphasize the importance of doctors speaking directly to their members about quitting. It can provide information and advice on speaking to members about potential long-term health implications related to tobacco use, strategies for tobacco cessation, and educating the patients on long-term health outcomes if they continue tobacco use versus tobacco cessation.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset patient, providing solutions, or making amends for problems that the patient reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

NHP: General Child CAHPS

Table 4-31 shows the general child CAHPS results for NHP for FY 2021–2022 through FY 2023–2024.

Table 4-31—General Child CAHPS Results for NHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	72.57%	70.92%	65.26%
Rating of All Health Care	65.22%$^{+}$	68.75%	60.82%$^{+}$
Rating of Personal Doctor	79.41%	71.81%	75.91%
Rating of Specialist Seen Most Often	68.18%$^{+}$	76.67%$^{+}$	79.31%$^{+}$

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Getting Needed Care	76.46%+	89.92%+	80.71%+
Getting Care Quickly	81.15%+	90.79%+	82.73%+
How Well Doctors Communicate	94.72%+	95.28%	91.16%+
Customer Service	82.10%+	96.31%+	88.37%+
Coordination of Care	81.82%+	84.09%+	75.61%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

NHP: Strengths

The following measures' FY 2023–2024 scores for NHP were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Customer Service*

The following measures' FY 2023–2024 scores for NHP were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measures' FY 2023–2024 scores for NHP were lower, although not statistically significantly, than the 2023 NCQA national averages:

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

- *Coordination of Care*

The following measures' FY 2023–2024 scores for NHP were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends NHP consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.
- Exploring ways to direct parents/caretakers of child members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child members perspectives. Physicians could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers.
- Involving staff members at every level to assist in improving the parent/caretaker of the child member's experience.
- Obtaining and analyzing parents'/caretakers' of child members experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, NHP reported engaging in the following QI initiatives:

- Providers were educated on the importance of referring members to smoking cessation programs and benefits. NHP's practice transformation coaches distributed a Frequently Asked Questions (FAQ) document about the Colorado QuitLine sheet and the updated Colorado QuitLine member tip sheet at NHP's practices. Further, NHP added these documents to its provider newsletter.
- Weld County's Tobacco Education and Prevention program implemented the rolling eight-week "Freedom From Smoking" sessions as part of an adult smoking cessation program from the American Lung Association. This program, available to all Weld County residents, was offered as a group program, online, or through a self-paced pamphlet. Group participants worked through the quitting process together under the direction of an expert "Freedom From Smoking" facilitator. Those who attended the group program were six times more likely to be tobacco-free one year later than those who attempted to quit on their own. Additional smoking cessation resources, specifically those that targeted teens and pregnant mothers, were posted on the Weld County Government website.
- Weld County's "Trusted Adult Start the Conversation" online classes were offered during quarters three and four on Tuesday evenings and Thursday afternoons via Zoom. These ongoing classes were offered every three months to parents, caregivers, school workers, community-based leaders, and youth-serving leaders. These types of programs experienced difficulty maintaining consistent participation. To combat this, NHP implemented a gift card raffle to those who registered and attended.
- Efforts were aligned with the Colorado Department of Public Health and Environment (CDPHE) to enhance NHP's smoking cessation tip sheet, which outlines the Colorado QuitLine benefits. This tip sheet included Prenatal Plus information for pregnant members and "My Life My Quit" information for teen members. Additionally, NHP had a "teen-friendly" information sheet with a QR code that linked to "My Life My Quit." These resources were available in both English and Spanish on NHP's website. NHP collaborated with CDPHE's tobacco cessation intervention coordinator during the reporting period to provide additional education and outreach to healthcare professionals regarding the Colorado QuitLine. NHP included the CDPHE's tobacco cessation intervention coordinator at NHP's care coordination meeting to review the Colorado QuitLine resources.
- A training for BH and PH providers was facilitated at a provider roundtable. NHP's goals for those trainings were aimed at educating healthcare professionals on the Colorado QuitLine, how to refer members to the program, and boosted the awareness and utilization of the Colorado Quitline. These trainings included an overview of services available such as Internet, text, and phone options for youth, American Indian, and BH populations. Further, the training included information about Health First Colorado benefits, various referral approaches, and a question/answer session.

- The objective to obtain and analyze data around members enrolled in the Colorado Quitline provided by CDPHE was met.
- The objective to promote the Weld County Department of Health and Environment (WCDPHE) smoking cessation classes on its social media sites was met. These smoking cessation classes were provided as an additional resource for care coordinators and coaches to share with members.
- The Virgin Pulse Text2Quit broad-based text campaign continued as part of its member engagement efforts toward tobacco cessation.
- CDPHE's tobacco cessation intervention coordinator was hosted at its "Getting Started" webinar. The webinar provided an overview of the Colorado QuitLine program. Members, family members, and healthcare professionals who were unable to attend the training could view the slide deck and recording on NHP's website.
- Colorado QuitLine health information sheets were distributed to healthcare professionals in its provider newsletters and on its social media sites. These resources were promoted at community, PT, QI, member advocate, and care coordination meetings.

Assessment of NHP's Approach to Addressing FY 2022–2023 CAHPS Recommendations

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

QUIP

NHP did not identify any scores under the 90 percent accuracy threshold during the FY 2022–2023 EDV and was therefore exempt from the QUIP.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that NHP maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of NHP's Approach to Addressing FY 2022–2023 QUIP Recommendations

NHP reported the decision to not take further action regarding recommendations due to overall low sample size and minimal areas of disagreement scores that were based on NHP staff member training needs regarding the USCS, not provider-focused opportunities. HSAG recognizes that while no additional action was needed from the provider, NHP has the opportunity to continue monitoring and ensure regular trainings for its internal staff members to maintain accurate auditing practices.

Mental Health Parity Audit

Table 4-32 displays the MHP Audit compliance scores for NHP for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-32—FY 2023–2024 MHP Audit Score for NHP

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
NHP	2	91%	Inpatient	89%	91%~
			Outpatient	93%	

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

NHP: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for NHP:

- NHP demonstrated an overall score of 91 percent.
- NHP's delegated UM vendor, Carelon, required its UM staff members to pass IRR testing annually with a minimum score of 90 percent, which was a 10 percent increase in the minimum score compared to the last review period (CY 2022).
- NHP demonstrated that Carelon used nationally recognized UR criteria (InterQual for MH determinations and ASAM LOCs for SUD determinations).
- Carelon followed its policies and procedures related to which services require prior authorization in most cases reviewed.
- Carelon notified providers of the denial determinations by telephone, secure email, and/or a copy of the NABD within the required time frame for all records reviewed.
- In all cases reviewed, the denial determination was made by a qualified clinician.
- Carelon provided evidence that a peer-to-peer review was offered to the requesting provider in all applicable cases except one.
- The NABDs contained the required information, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from NHP in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative LOC, if applicable. Additionally, the inpatient SUD NABDs included the required language regarding how each ASAM dimension was considered when determining medical necessity.

- During the MHP interview, Carelon staff members reported hiring a new staff member to lead the process for reviewing Independent Assessments (IAs) for qualified residential treatment program placements. The new staff member would provide additional support and assistance to UM and care management staff members, including working with the parent/guardian and obtaining additional information. Additionally, Carelon brought on a dedicated MD for the Colorado contract for UR who specifically understands Colorado regulations and standards.

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

HSAG found the following opportunities for improvement:

- Carelon demonstrated in multiple records that the NABD was not always sent to the member within the required time frame.
- One record did not contain evidence that a peer-to-peer review was offered to the requesting provider.
- Within one record reviewed, Carelon did not document the UR criteria (InterQual or ASAM) used to make the medical necessity denial determination.
- In one record reviewed, Carelon did not reach out to the requesting provider for additional documentation to determine medical necessity.

To address these opportunities for improvement, HSAG recommends NHP:

- Enhance Carelon's monitoring mechanisms to ensure that the member is issued an NABD within the required time frame.
- Follow established policies and procedures to ensure that requesting providers are consistently offered a peer-to-peer review.
- Ensure all denial determinations due to medical necessity use established UR criteria (InterQual or ASAM) and that staff members document in the UM system the criteria used.
- Enhance monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended NHP:

- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.

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

Assessment of NHP's Approach to Addressing FY 2022–2023 MHP Recommendations

NHP reported addressing HSAG's recommendations by:

- Training UM staff members on required time frames and meeting internally with the letters team to improve turnaround time compliance in regard to sending NABDs to members and providers.
- Discussing with internal staff members readability within the NABDs to ensure narratives are easy to understand for members.

NHP still has the opportunity to address HSAG's recommendation of enhancing monitoring mechanisms to ensure the member is notified of the denial determination within the required time frame. NHP's reported updates will likely demonstrate improvement to overall UM processes. NHP should continue to address the recommendations by HSAG to increase MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, Carelon investigated nine potential QOCG cases on behalf of NHP. NHP's average membership in CY 2023 was 105,063, with 89,868 members enrolled as of December 31, 2023. Of the nine QOCG cases submitted by Carelon, two cases were substantiated.

NHP: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for NHP:

- All potential QOCGs are reviewed by the Quality-of-Care Committee. Staff members from both Carelon and NHP comprise the committee, which determines whether the QOCG is *Founded*, *Unfounded*, or *Unable to Determine*.
- Carelon and NHP staff members verified that no CAPs were issued during the CY 2023 review period; nevertheless, Carelon staff members further described the CAP procedures outlined in the policies and procedures, including how the Quality Connect system monitors the CAPs and how all communication regarding the CAP is documented in the system.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- Carelon reported that only cases submitted by members receive follow-up.
- Carelon's policy for timeliness states that investigations are to be completed within 60 calendar days from the day the QOCG is reported to Carelon. One of the nine cases reviewed did not meet Carelon's timeliness requirements.
- Based on instruction from a previous Department employee, NHP sends quarterly reports to the Department only detailing cases with the determination of *Founded*.

To address these opportunities, HSAG recommends that NHP:

- Consider revision of the definition of "Unfounded" as it currently dismisses any QOCG that occurred if the provider "lacked knowledge" or was "not able to act" in a way to successfully avoid the potential QOCG for the member. The current definition may inadvertently dismiss QOCGs where provider training and education could be beneficial.
- Establish a clear process to ensure that member follow-up is occurring to determine whether the member's immediate healthcare needs are being met, regardless of where the QOCG originates.
- Implement a process for notifying the Department that a QOCG has been received and include submission of a QOC summary for all cases, as outlined in the MCE contract.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023; however, NHP reported ongoing QI efforts to address the FY 2021–2022 recommendations.

Assessment of NHP's Approach to Addressing FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

NHP reported addressing HSAG's recommendations by:

- Assessing whether the incident qualifies as a potential QOCG. This determination is made using CMS' definition of a potential QOCG as "a type of grievance that is related to whether the quality of covered services provided by the health plan or provider meets professionally recognized standards of health care including whether appropriate health care services have been provided or have been provided in appropriate settings." Investigations into potential QOCG concerns are conducted by the Quality Management Department, and the findings are evaluated by the Quality-of-Care Committee for appropriate follow-up, corrective actions, and monitoring. The Quality-of-Care Committee meets every other Tuesday, up to three times per month, an increase from the previous year.

- Clarifying that providers, NHP staff, or other concerned parties can report potential QOCG issues through an adverse incident reporting form, which can be submitted to the Quality Management Department via a designated email address or a confidential secure fax. The adverse incident form is available on the RAE website and is provided digitally to providers upon their request. Providers are informed of the reporting process at quarterly documentation training events and through mass distribution emails at least twice per year.
- Documenting all potential QOCGs and presenting them to the Quality-of-Care Committee, which reviews the investigation and determines the findings based on the facts of each case. Corrective actions are tracked and monitored until closure. The reporting, investigation, and tracking of potential QOCGs by the Quality Management Department are reported to the Department quarterly, as required. Policies and procedures, along with workflows, are updated to comply with contract requirements, as necessary.

HSAG anticipates NHP's responses to the recommendations have a moderate likelihood to improve overall processes and increase NHP's understanding and implementation of the Colorado-specific QOCG process. NHP should continue addressing the recommendations made by HSAG for continuous improvement.

EPSDT Audit

Table 4-33 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-33—FY 2023–2024 EPSDT Audit Findings for NHP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	25%	63%
Post-Denial Record Review	83%	33%	67%

NHP: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for NHP:

- NHP submitted extensive evidence to demonstrate its adherence to the EPSDT policy and in its Annual EPSDT Outreach Strategic Plan that education and training is completed annually and additional training, oversight, and feedback occurs consistently throughout the year.

- NHP staff described an increase in content audits related specifically to EPSDT in the UM and care coordination departments.
- Meeting minutes from the NHP Care Coordination Subcommittee demonstrated best practices in monitoring, auditing, and performing quality assurance checks on complex member cases and ensuring adherence to outreach and engagement expectations.
- Multiple cases demonstrated that NHP outreached the member within 48 hours of discharge or denial determination.
- NHP demonstrated improvements in care coordination documents for EPSDT in FY 2022–2023 compared to FY 2021–2022.
- NHP had various outreach campaign types regarding well-child visits, vaccinations, dental services, developmental SMS text messages, and other benefits and services available to the members. The messaging detailing assistance available to members was determined to be a best practice.
- NHP was one of two MCEs with reported mechanisms to track returned mail rates.

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

HSAG found the following opportunities for improvement:

- Carelon did not have a consistent process to clearly document a secondary review, in addition to InterQual or ASAM, was conducted for EPSDT members prior to issuing a denial.
- The denial samples reviewed showed that NHP did not send an NABD to members regarding their denial in three of the 15 samples, all of which were administrative denials.
- Two denial cases demonstrated that care coordination was offered, but the cases were closed due to not being able to contact the member after two business days.
- A care coordination assessment given to the member included a decision point for Carelon care coordination staff members to assess whether they think it is beneficial to continue the assessment, which seemed to limit completion of the full assessment and the opportunity for the member/parent/guardian to identify additional healthcare needs.
- Carelon staff members shared that outreach efforts to the non-utilizer members within the sample were minimal and revealed less outreach than expected from its vendor.

To address these opportunities for improvement, HSAG recommends NHP:

- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to InterQual or ASAM, prior to issuing a denial.

- Update its UM procedures to include administrative denials (any denial, in whole or in part, of payment for a service that involves anything other than a clean claims issue) to ensure members are informed of decisions about their healthcare and informed of appeal rights.
- Consider the addition of a minimum time the care coordination case remains open in addition to its policy requiring three outreach attempts and at least two outreach modalities.
- Review and further adapt its assessment tools to ensure the member/parent/guardian has ample opportunity to communicate any healthcare needs.
- Perform quality checks both internally and with the texting vendor to ensure consistent outreach is occurring to the non-utilizer members, including when the first outreach attempt is unsuccessful.

During the FY 2023–2024 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- All members within the non-utilizer sample received at least one outreach; however, only two members received more than one outreach attempt. 

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

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended NHP:

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

Assessment of NHP's Approach to Addressing FY 2022–2023 EPSDT Recommendations

NHP reported addressing HSAG's recommendations by:

- Developing an EPSDT referral process and RAE care coordination template. The template documents the procedures for NHP's UM team to follow in obtaining EPSDT services for members.
- Expanding documenting in its electronic health record (EHR) to demonstrate that UM staff members considered the member's needs, environment, and how to assist the member in achieving or maintaining maximum functional capacity.

- Creating an EPSDT documentation template for the UM staff members to serve as a guide for noting medical necessity considerations for EPSDT members. Additionally, the template serves as a reminder to UM managers to record when referrals for care coordination have been completed.
- Conducting several EPSDT trainings during Provider Roundtable sessions and with UM and call center staff members.

NHP still has the opportunity to address HSAG's recommendation of discussing with the Department whether voicemails may be considered completed outreach. NHP's responses to the recommendations are likely to improve UM processes. NHP should continue to address the recommendations by HSAG to ensure member awareness and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-34 displays the percentage of cases reviewed that HSAG's reviewers determined adhered to ASAM criteria.

Table 4-34—NHP Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
NHP	26	22[1]	15	68%

[1] *Four samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 22.*

Table 4-35 presents the number of cases in the sample that HSAG reviewed for NHP and the percentage of cases in which HSAG's reviewers agreed with NHP's denial determination.

Table 4-35—NHP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
NHP	26	22[1]	16	73%

[1] *Four samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 22.*

NHP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found that while NHP did not exceed minimum expectations, it demonstrated improvement from the previous review period regarding sending the member an NABD after the denial decision and followed standard best

practices, including using a two-step review process that included UM staff members with appropriate credentials.

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

HSAG found the following opportunities for improvement:

- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations.
- Although it is best practice for facilities to begin discharge planning upon the member's admission, many cases demonstrated a delay in discharge planning, resulting in members being denied additional coverage without a stable discharge plan, which increased relapse risk.
- While NHP demonstrated improvement from the previous review regarding sending the member an NABD after the denial decision, half of the NABDs within the sample were untimely.
- In many cases, NHP UM reviewers justified denial of 3.1 and 3.5 LOCs by stating that members were stabilized in dimensions 1–3; however, stabilization in those dimensions is an admissions requirement for these LOCs.

To address these opportunities for improvement, HSAG recommends NHP:

- Host training for providers and UM reviewers regarding the importance of considering the member's interdimensional interactions and co-occurring problems during the review process.
- Provide additional training for providers regarding discharge planning as well as using care coordination and other available resources to provide assistance with discharge planning and continuity of care.
- Enhance monitoring mechanisms to ensure adherence to the required time frame for notifying the member of the denial determination.
- Provide additional training to UM reviewers regarding appropriate criteria for LOCs, specifically how UM reviewers should consider dimensions 4–6 when making determinations for residential LOCs.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that NHP:

- Perform immediate updates to the system to ensure that denials are not recorded when no request for services has been submitted.

- Update its policies, procedures, and processes to ensure that sufficient clinical documentation is received and included in each service authorization file to support the authorization approval or denial.
- Update policies, procedures, and processes to ensure that members receive the correct NABD template.

Assessment of NHP's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

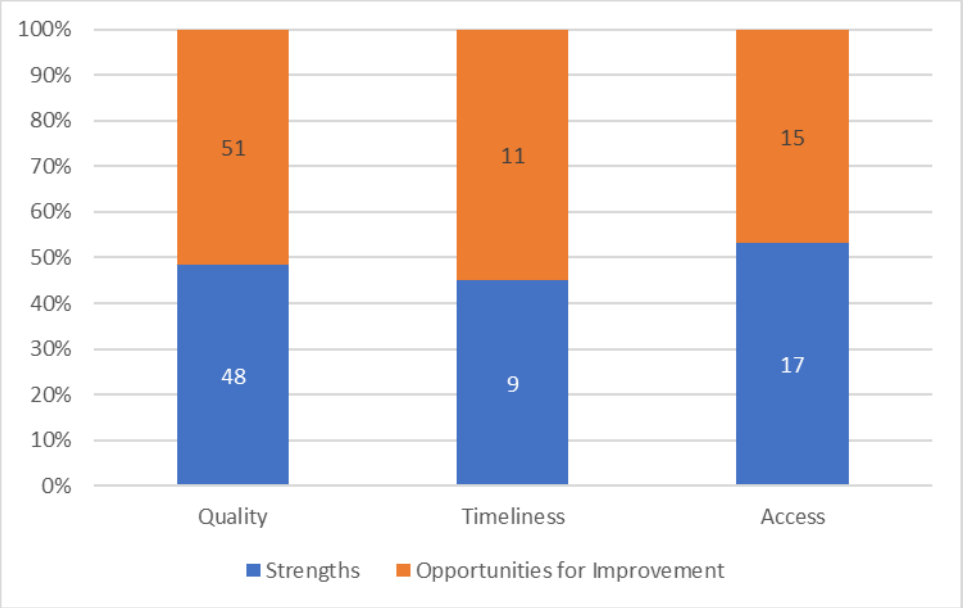
NHP reported addressing HSAG's recommendations by:

- Reviewing SUD report findings with the UM team.
- Completing a UM training regarding clearer documentation of administrative denial reasons, documentation of peer-to-peer reconsiderations, and SUD UM turnaround times.
- Providing additional training for UM staff members to include more specific language in ASAM documentation, continued stay and discharge criteria, special populations, as well as incorporating the members' progress on their treatment goals into documentation.
- Revising internal language used for medically necessary denials to include more detail and full ASAM criteria that were not met.
- NHP's UM team attended the ASAM criteria training arranged by the Department.
- Onboarding a dedicated medical director to help ensure consistency in application of ASAM criteria and review determinations.
- Standardizing verbiage in continued stay reviews to assist in capturing necessary clinical documentation such as treatment plan progress, ASAM criteria, and discharge planning.
- Enhancing internal chart audits to include specific SUD audit finding items which include EPSDT considerations, ASAM criteria, special population considerations, and care coordination referrals.

HSAG anticipates NHP's responses to the recommendations are likely to improve overall processes and increase NHP's understanding and implementation of ASAM criteria. NHP should continue addressing the recommendations made by HSAG for continuous improvement.

Region 3—Colorado Access

Figure 4-3—Number of Strengths and Opportunities for Improvement by Care Domain for COA Region 3*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

COA Region 3 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP and the nonclinical *Social Determinants of Health (SDOH) Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. COA Region 3 resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 4-36 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUH*

Table 4-36—2023–2024 PIP Overall Confidence Levels for the *FUH* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUH* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA Region 3 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-37—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	75%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA Region 3 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUH*

Table 4-38 displays data for COA Region 3's *FUH* PIP.

Table 4-38—Performance Indicator Results for the *FUH* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for Region 3 members 6 years of age and older who were hospitalized for treatment of	N: 1,102	45.59%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	D: 2,417						

N–Numerator D–Denominator

For the baseline measurement period, COA Region 3 reported that the percentage of 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 was 45.59 percent.

Nonclinical PIP: *SDOH Screening*

Table 4-39 displays data for COA Region 3's *SDOH Screening* PIP.

Table 4-39—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of Region 3 members who were screened for SDOH using the Core 5 SDOH screening tool.	N: 0 D: 4,980	0%					

N–Numerator D–Denominator

For the baseline measurement period, COA Region 3 reported that 0 percent of Region 3 members were screened for SDOH using the Core 5 SDOH screening tool.

Interventions

Clinical PIP: *FUH*

Table 4-40 displays the barriers and interventions documented by the health plan for the *FUH* PIP.

Table 4-40—Barriers and Interventions for the *FUH* PIP

Barriers	Interventions
Care manager challenges with the existing member outreach process due to the following barriers: • Volume of work is too high • Intervention does not feel meaningful • Not enough time to serve members with complex needs • High administrative burden for high volume of members	**Colorado Access care coordination for members with inpatient mental health admissions:** Colorado Access' BH program has been streamlined to improve the member outreach process. Care managers coordinate care with providers, connect members with appropriate outpatient BH services, and mitigate barriers to discharge or engagement in follow-up services. The new approach stratifies members by risk level to reduce the overall volume of admissions and to provide an additional touchpoint to members in the seven days following discharge to promote successful follow-up appointment attendance.
• Community Mental Health Centers (CMHCs) not being notified when a member had an inpatient hospital admission, and having difficulty identifying members who needed a follow-up appointment after discharge. • Hospitals have difficulty identifying members who were already engaged in BH services with a CMHC or other BH provider, so they did not know where to get a member connected for a follow-up appointment.	**Hospital, CMHCs, and Care Management seven-day follow-up dashboard:** Colorado Access worked to build a system that connects hospitals, CMHCs, and our internal care management team to coordinate discharge planning. Colorado Access has implemented a multi-faceted dashboard that hospitals, CMHCs, and the Colorado Access Care Management team can utilize to connect discharged members to BH providers in real-time. CMHCs can now access this dashboard system to see where their members are hospitalized in real-time and preemptively coordinate a follow-up appointment after discharge. They can also see their seven-day follow-up performance rate in real-time. Additionally, hospitals can now see which members are already connected to CMHCs so they can coordinate more targeted discharge and access other BH outpatient options besides CMHCs if appointment availability is limited within the seven-day time frame. This intervention will build community partnerships between hospitals and outpatient BH providers.
CMHCs need for more financial support and incentive to dedicate resources and staffing for 7-day follow-up rate improvement efforts.	**New Value-Based Payment Model for CMHCs:** Colorado Access recently enacted a new value-based payment model for the seven-day follow-up after hospitalization for mental illness metric to all CMHCs. If this *FUH* metric improves, CMHCs will receive additional payment.

Nonclinical PIP: *SDOH Screening*

Table 4-41 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-41—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Existing care management scripts ask members a variety of SDOH questions that do not cover all 5 SDOH core domains.	Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable care management scripts.
The internal Colorado Access HealthEdge GuidingCare system has not been updated since 2021. The older system has impacted the ability to update the care management scripts and workflows within the GuidingCare system in a timely manner.	**Optimization of the collection of SDOH data and reporting within HealthEdge GuidingCare.** The updated and upgraded GuidingCare system incorporates the SDOH Core 5 screening tool into the new and improved system and scripts.

COA Region 3: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- COA Region 3 reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

COA Region 3: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. COA Region 3 addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and COA Region 3 received *High Confidence* for the final Module 4 submission. COA Region 3's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-42 shows the performance measure results for COA Region 3 for MY 2021 through MY 2023.

Table 4-42—Performance Measure Results for COA Region 3

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	45.09%	51.53%	52.20%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	56.76%	46.84%	47.43%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	30.50%	26.30%	28.16%	40.14%
Follow-Up After a Positive Depression Screen	43.47%	46.66%	43.33%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	15.41%	14.63%	9.92%	36.42%

COA Region 3: Strengths

The following performance measure rates for MY 2023 increased from the previous year for COA Region 3:

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*

For MY 2023, none of the measure rates exceeded the established performance measure target.

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

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

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*

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

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

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[27]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended COA Region 3:

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

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

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

- Ongoing work within its BH program that is designed to identify and intervene with members using bed-based BH services, including inpatient and residential, to prevent readmission. Care managers coordinate care with providers, connect members with appropriate outpatient BH services, and mitigate barriers to discharge or engagement in follow-up services.
- New steering councils and committees have been formed to recommend strategies to improve performance metrics and support workgroups for enhancing population health outcomes by prioritizing measures for high-impact areas of improvement and increased collaboration among providers to share best practices and scale interventions across the network.

HSAG recognizes that the BH care coordination program and new steering committees are likely to help improve and maintain performance rates.

[27] Ibid.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 3 Overall Evaluation

Table 4-43 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-43—Summary of COA Region 3 Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	17	1	0	0	94%~
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%v
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**49**	**5**	**0**	**0**	**91%**

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

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

~ *Indicates no change from review three years prior.*

COA Region 3: Trended Performance for Compliance With Regulations

Table 4-44 presents, for all standards, the overall percentage of compliance score for COA Region 3 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-44—Compliance With Regulations—Trended Performance for COA Region 3

Standard and Applicable Review Years	COA Region 3 Average—Previous Review	COA Region 3 Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	80%	91%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	100%	100%

Standard and Applicable Review Years	COA Region 3 Average—Previous Review	COA Region 3 Average—Most Recent Review
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	100%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**94%**	**94%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	80%	94%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**100%**	**94%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**100%**	**25%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	88%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, COA Region 3 demonstrated consistently high-achieving scores for three standards, one of which maintained 100 percent compliance from the previous review cycle, and the other maintained 94 percent compliance, indicating a strong understanding of most federal and State regulations. Scores for two standards, Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation, both declined from the previous review cycle with the most notable decrease of 75 percentage points for Standard IX—Subcontractual Relationships and Delegation.

COA Region 3: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 maintained policies pertaining to effective communication, accessibility, and cultural sensitivity that outlined the steps COA Region 3 takes to ensure effective communication with members, including testing readability, keeping the message simple, and understanding the audience. 

- COA Region 3 established a clear reporting structure from the Core Policy team and Provider Performance Committee up through the Executive Compliance Committee to the Finance, Audit, and Compliance Committee (FACC), and ultimately to the Board of Directors.
- Within its QAPI Program Description and Annual Quality Report, COA Region 3 described a comprehensive program that included processes to address the appropriateness of care, quality of care, and member experience. The quality and appropriateness of care for members with SHCN were addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.
- COA Region 3 reviewed CPGs annually and included a process for soliciting feedback from contracted providers. The CPGs were adopted and disseminated to providers and members.

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

HSAG found the following opportunities for improvement:

- Within its electronic provider directory, COA Region 3 did not include the provider website URLs, as required.
- Policies and procedures did not state that COA Region 3 would not knowingly employ any staff members who are "debarred" or "suspended" from participation in federal programs.
- Staff members were unaware of the status of active delegation agreements and were unable to communicate a current process that addressed poor subcontractor performance.
- One delegation agreement did not include the delegated activities or obligations and related reporting responsibilities.
- Some written delegation agreements did not include all of the required language.

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

- Update its provider directory to include the provider URLs.
- Revise its policies and procedures to align in full detail with the federal and State requirements.
- Maintain ultimate responsibility of subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
- Ensure that all delegation agreements specify the delegated activities or obligations and related reporting responsibilities.
- Revise or amend the written delegation agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended COA Region 3:

- Update its procedures to further delineate provider administrative clean claims which are separate from member-related issues in which a service is denied or partially denied. Additionally, enhance policies, procedures, and monitoring to ensure that the member is notified in writing of the denial or partial denial of a service.
- Enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.
- Enhance its monitoring system to ensure that grievance acknowledgement letters are sent in a timely manner.
- Remove the inaccurate statement in its Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, COA Region 3 updated policies, procedures, and monitoring to ensure that the member is notified in writing of the denial or partial denial of a service and decisions are made within the required time frame. In addition, COA Region 3 enhanced its monitoring system to ensure grievance acknowledgement letters were sent in a timely manner and removed inaccurate language in the policy that directed the member to follow up an oral appeal request in writing. HSAG recognizes updating policies and procedures and enhancing monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

COA Region 3: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 met the minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.
- COA Region 3 met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Family Practitioner (MD, DO, NP, CNS, and PA) in 50 percent of all contracted counties. In the counties where COA Region 3 did not meet the minimum requirements for these provider categories, access was greater than 90 percent.
- While COA Region 3 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in only 25 percent of all contracted counties, the level of access for these provider types in all contracted counties was greater than 91.1 percent.
- COA Region 3 improved upon its provider specialty matching since converting to the use of HealthRules Payor (HRP), as it now relies solely upon the use of taxonomy codes for specialty matching instead of its previous process that included the use of multiple values (i.e., specialty description and provider types) to identify provider specialty.
- COA Region 3 maintains detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.

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

HSAG found the following opportunities for improvement:

- COA Region 3 did not consistently meet the minimum network requirements for any SUD Treatment Facilities–ASAM LOCs across any of the contracted counties. Within these provider types, compliance with minimum network requirements varied greatly. SUD Treatment Facilities–ASAM LOCs 3.2 WM, 3.3, and 3.7 reflected rates of 0 percent access across all contracted counties. However, SUD Treatment Facilities–ASAM LOCs 3.1, 3.5, and 3.7 WM demonstrated rates of 98 percent or greater access in 75 percent of contracted counties, with the exception of Elbert County, where access ranged from 11.5 percent to 76.6 percent.

- COA Region 3 did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any of the contracted counties.
- COA Region 3 indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when COA Region 3 is informed of a change in member demographic information.

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

- Conduct an in-depth review of provider categories for which COA Region 3 did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that COA Region 3 continue to conduct an in-depth review of provider categories for which COA Region 3 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that COA Region 3:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, COA Region 3 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure COA Region 3's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Reported that the inability to meet indicated time and distance standards is due to the taxonomy codes for SUD treatment facilities (particularly ASAM LOC 3.1 and above) not tracking to the correct category. COA Region 3 stated it obtains taxonomy code information from the Department MCO report based on how providers fill out their information for the Department's provider validation. However, these taxonomy codes do not always align with a provider's National Provider Identifier (NPI) provider type and may not be validated at the location level.
- Updated the provider directory with data refreshed every evening. COA Region 3 reported that within its directory a form is available that anyone, including members, may use to report incorrect data or issues accessing providers listed in the directory.
- Described that all credentialed providers are listed in COA Region 3's provider directory with information related to provider specializations, location, clinic office hours, status of accepting new members, cultural competency, race/ethnicity, gender, pronouns, Americans with Disabilities Act (ADA) accessibility, and languages spoken. The provider directory also lists all BH subspecialties and ASAM LOCs, increasing the ability to identify and connect members to the appropriate level of specialized care.
- Reported that credentialing and provider data maintenance teams at COA Region 3 entered provider data into COA Region 3's credentialing database using several different sources including information provided through the provider application and required appendix, as well as CAQH summaries.

Based on the above response, COA Region 3 worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-45 presents COA Region 3's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-45—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for COA Region 3

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	86.1%	98.5%
Diagnosis Code	86.1%	90.5%	95.6%
Place of Service	NA	66.4%	98.5%
Service Category Modifier	NA	85.4%	98.5%
Units	NA	94.2%	97.8%
Revenue Code	90.5%	NA	NA
Discharge Status	90.5%	NA	NA
Service Start Date	94.2%	93.4%	98.5%
Service End Date	35.8%	93.4%	98.5%
Population	NA	94.2%	98.5%
Duration	NA	92.7%	97.8%
Staff Requirement	NA	88.3%	97.1%

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

Table 4-46 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with COA Region 3's EDV results for each of the validated data elements.

Table 4-46—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for COA Region 3

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	100.0%	100.0%
Diagnosis Code	100.0%	100.0%	100.0%
Place of Service	NA	100.0%	100.0%
Service Category Modifier	NA	100.0%	100.0%
Units	NA	100.0%	100.0%
Revenue Code	100.0%	NA	NA
Discharge Status	100.0%	NA	NA
Service Start Date	100.0%	100.0%	100.0%
Service End Date	100.0%	100.0%	100.0%

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	90.0%	100.0%

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

COA Region 3: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 self-reported high overall accuracy with 90 percent accuracy or above for three of the five inpatient services data elements, six of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that COA Region 3's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with all five inpatient services data elements, nine of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in COA Region 3's EDV results, COA Region 3's self-reported EDV results for inpatient services and psychotherapy services demonstrated a moderate level of encounter data accuracy, with a 35.8 percent accuracy rate for the *Service End Date* inpatient services data element and a 66.4 percent accuracy rate for the *Place of Service* psychotherapy services data element when compared to the corresponding medical records.

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

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended COA Region 3 consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

COA Region 3 reported implementing CAPs for providers with a sufficient number of records that scored below a 95 percent in the RAE 411 over-read. The CAPs included a root-cause analysis, retraining staff, enhancing systems, and provider re-audits. COA Region 3 also reported offering provider education and training on quality documentation.

Based on COA Region 3's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

COA Region 3: Adult CAHPS

Table 4-47 shows the adult CAHPS results for COA Region 3 for FY 2021–2022 through FY 2023–2024.

Table 4-47—Adult CAHPS Results for COA Region 3

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	53.96%	54.94%	65.76% ▲
Rating of All Health Care	60.47%+	48.21%	54.07%
Rating of Personal Doctor	61.68%	62.07%	75.17% ▲ ↑
Rating of Specialist Seen Most Often	68.97%+	63.24%+	59.78%+
Getting Needed Care	77.77%+	72.07%+	80.52%
Getting Care Quickly	77.87%+	71.90%+	81.35%+
How Well Doctors Communicate	88.78%+	90.22%+	95.64% ↑
Customer Service	82.22%+	81.71%+	87.05%+
Coordination of Care	85.71%+	71.93%+	86.67%+ ▲
Advising Smokers and Tobacco Users to Quit	70.37%+	67.24%+	68.66%+

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Discussing Cessation Medications	51.85%+	46.55%+	46.27%+
Discussing Cessation Strategies	44.44%+	44.64%+	41.27%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

COA Region 3: Strengths

The following measures' FY 2023–2024 scores for COA Region 3 were statistically significantly higher than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for COA Region 3 were statistically significantly higher than the FY 2022–2023 scores:

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

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

The following measures' FY 2023–2024 scores for COA Region 3 were lower, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Customer Service*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

The following measures' FY 2023–2024 scores for COA Region 3 were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Specialist Seen Most Often*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

- Obtaining feedback from members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Involving staff members at every level to assist in improving the member experience.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with members. Specialists could ask questions about members' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their condition and the actions they will take to monitor and manage members' conditions in the future, as well as follow up with any concerns that members might have about their healthcare.
- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset patient, providing solutions, or making amends for problems that the patient reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Providing internal training sessions and sending out newsletters designed to educate providers on the importance of guiding and advising smokers and tobacco users to quit. The training could emphasize the importance of doctors speaking directly to their members about quitting. It can provide information and advice on speaking to members about potential long-term health implications related to tobacco use, medications and strategies for tobacco cessation, and educating the patients on long-term health outcomes if they continue tobacco use versus tobacco cessation.

COA Region 3: General Child CAHPS

Table 4-48 shows the general child CAHPS results for COA Region 3 for FY 2021–2022 through FY 2023–2024.

Table 4-48—General Child CAHPS Results for COA Region 3

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	74.25%	66.55%	73.91%
Rating of All Health Care	64.89%	65.34%	69.68%
Rating of Personal Doctor	72.08%	71.74%	70.28%
Rating of Specialist Seen Most Often	75.00%+	61.29%+	63.46%+
Getting Needed Care	83.60%+	75.47%	80.77%
Getting Care Quickly	86.86%+	83.93%	83.81%
How Well Doctors Communicate	91.64%	92.73%	92.62%
Customer Service	88.66%+	88.10%+	90.35%+
Coordination of Care	80.65%+	85.56%+	80.70%+

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 2023 NCQA national average.*
↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*
▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*
Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

COA Region 3: Strengths

The following measures' FY 2023–2024 scores for COA Region 3 were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for COA Region 3 were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measures' FY 2023–2024 scores for COA Region 3 were lower, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for COA Region 3 were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Personal Doctor*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Coordination of Care*

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

- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Exploring ways to direct parents/caretakers of child members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

- Obtaining and analyzing parents'/caretakers' of child members experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child members perspectives. Physicians could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, COA Region 3 reported engaging in the following QI initiatives:

- In addition to CAHPS results, supplemental feedback was gathered through member satisfaction surveys, developed with input from members and member-facing teams. Those surveys provided actionable insights and were guided by the Member Advisory Council, internal teams, and population health data. In spring 2023, questions on racial, cultural, and ethnic identities, as well as general member experience questions, were included in the survey. By spring 2024, COA continued with recurring questions on improvement to the member experience and added questions on health-related social needs and member communication preferences. COA is developing a new initiative to create a community feedback loop. This project will be aimed at assessing the current state of how COA seeks member feedback, pilot an improved member feedback loop model, and explore incentive models for member and community participation.
- With its commitment to understanding and addressing disparities within its population that may contribute to lower performance among specified race or ethnicity groups, age groups, ZIP Codes, and other demographics, COA conducted an internal satisfaction survey, which was designed to collect comprehensive information on member demographics. This allowed COA to analyze qualitative responses such as access to care issues and timeliness of services in conjunction with demographic data.
- A CAHPS communication plan was developed and implemented. The plan included detailed information on the CAHPS survey, covering its purpose; data collection timeline; and its benefits to members, providers, and the Health First Colorado system. This information, along with links to CAHPS results, were communicated through various channels such as the provider manual, the monthly provider updates, the internal COA employee newsletter, the member newsletter, and COA's social medical platforms. Provider-facing teams were available to address any provider questions regarding the CAHPS survey and reported any barriers encountered to internal staff members.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 CAHPS Recommendations

HSAG has determined that COA Region 3 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with COA Region 3.

QUIP

Table 4-49 presents COA Region 3's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-49—Summary of COA Region 3 QUIP Outcomes

Service Categories	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Procedure Code	89.8%	50%	100%	100%
	Place of Service	86%	0%	0%	0%
	Service Category Modifier	89.8%	50%	100%	NA

**Red shading indicates accuracy of less than 90 percent; green shading indicates accuracy of 90 percent and higher.*
NA indicates the MCE did not have baseline scores under 90 percent; therefore, no comparisons can be made.

COA Region 3: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- For psychotherapy services, COA Region 3 surpassed 90 percent accuracy for one out of the three data elements. Most notably, two data elements started with 89.8 percent accuracy, both decreased to 50 percent accuracy in month one, then improved to 100 percent accuracy in month two, and by month three, one of the two remained at 100 percent.
- Key interventions for the QUIP consisted of a CAP, additional training, and education on the topic of technical documentation requirements as well as an agency electronic medical record correction.

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

HSAG found the following opportunities for improvement:

- COA Region 3 reported 0 percent accuracy for one data element due to insufficient documentation. Providers submitted less charts than expected due to low claims availability for the pilot providers, and the scores are based on two charts in month one and only one chart in both months two and three.

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

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that COA Region 3 maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 QUIP Recommendations

COA Region 3 reported that it implements CAPs for providers that score below 95 percent encounter accuracy in the 411 EDV and requests enough records to assess general documentation practices. COA Region 3 has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that the implementation of CAPs for providers that score below 95 percent encounter accuracy is likely to improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-50 displays the MHP Audit compliance scores for COA Region 3 for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-50—FY 2023–2024 MHP Audit Score for COA Region 3

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
COA	3	96%	Inpatient	95%	95%v
			Outpatient	95%	

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

COA Region 3: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 used nationally recognized UR criteria (InterQual for MH determinations or ASAM LOCs for SUD determinations) in all records reviewed except one.
- COA Region 3 required its UM staff members to pass IRR testing annually with a minimum score of 90 percent or better.
- All files except one demonstrated that COA Region 3 followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services.
- COA Region 3 utilized *The ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice.
- COA Region 3 made the denial determinations within the required time frame, and providers were notified of the denial determinations in all cases except one. Providers were notified by telephone, secure email, and/or a copy of the NABD.
- Most records reviewed demonstrated that the member was sent the NABD within the required time frame.
- In one record reviewed, COA Region 3 utilized an extension to obtain additional information and sent the extension letter, which included the required content, to the member within the required time frame.

- In all cases reviewed, the denial determination was made by a qualified clinician. Additionally, in most applicable cases, the records contained evidence that a peer-to-peer review was offered to the requesting provider.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system.
- All NABDs included the required content, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA Region 3 in filing an appeal, access to pertinent records, and a brief reason for the denial.
- COA Region 3 staff members described updates to COA Region 3's UM software system, which included enhanced oversight capabilities, allowing for additional monitoring of how UM staff members interact and follow up with care management. Furthermore, when communicating with providers regarding UM changes or updates, COA Region 3 described organizational efforts to communicate with providers through the provider-facing website, newsletters, and direct fax blasts.

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

HSAG found the following opportunities for improvement:

- In multiple instances, COA Region 3 did not notify the provider of the denial or send an NABD to the member within the required time frame.
- One record review did not contain evidence that a peer-to-peer review was offered to the requesting provider.
- Within two records reviewed, COA Region 3 did not demonstrate the use of established UR criteria (InterQual or ASAM).
- In two records reviewed, COA Region 3 did not outreach the requesting provider for additional documentation to determine medical necessity.
- One NABD did not list the required ASAM dimensions considered in making the denial determination.

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

- Enhance monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.

- Follow established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- Provide continuous staff member training to ensure that staff members document and save UR criteria (InterQual or ASAM) in the UM system and that all denial determinations due to medical necessity use established criteria.
- Enhance monitoring procedures to ensure that COA Region 3 reaches out to the requesting provider for additional documentation, when needed, particularly for ASAM LOCs.
- Include each of the required ASAM dimensions in the inpatient and SUD NABDs and conduct periodic chart audits to ensure consistency.
- As a best practice, include in the NABDS (other than the SUD NABDs, which mostly included the required ASAM dimensions) reference to COA Region 3's criteria (i.e., InterQual) used in making the determination and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 3 found to be present or not present related to the criteria).

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended COA Region 3:

- Enhance monitoring mechanisms to ensure the member is informed of the denial within the required time frame.
- Enhance monitoring procedures to ensure additional outreach occurs with the requesting provider when adequate documentation is not received.
- Conduct periodic staff training and monthly record audits to ensure that NABDs are at an easy-to-understand reading grade level.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 3 found to be present or not present related to the criteria).

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 MHP Recommendations

COA Region 3 reported addressing HSAG's recommendations by:

- Reviewing and optimizing internal processes to ensure timely communication of denial determinations and emphasizing the importance of adhering to time frames to ensure compliance during staff trainings.
- Providing ongoing training for staff members to ensure staff members are proficient in applying InterQual and ASAM criteria consistently. Additionally, COA Region 3 reported reviewing regular

auditing metrics and procedures to confirm accurate analysis of team performance as it relates to denial determinations.

- Conducting staff training and record audits for COA Region 3 UM staff members.
- Including more specific information in NABDs regarding the member's condition that are meant to convey the criteria and reason for the denial determination and evaluating the NABD templates for improvement.

COA Region 3 still has the opportunity to address HSAG's recommendation of enhancing monitoring mechanisms to ensure the provider and member receive information regarding the denial determination within the required time frame, enhancing monitoring procedures to ensure additional outreach with the requesting provider when adequate documentation is not received, and including the specific name of the criteria (i.e., InterQual) used to make the denial determination in the NABD. HSAG acknowledges that COA Region 3 pursued additional guidance from HSAG and the Department regarding NABD template updates to include InterQual language in a manner that is member friendly. COA Region 3's reported updates will most likely demonstrate improvement to overall UM processes. COA Region 3 should continue to address the recommendations made by HSAG to increase MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, COA Region 3 investigated 78 potential QOCG cases. COA Region 3's average membership in CY 2023 was 358,256, with 306,960 members enrolled as of December 31, 2023. Of the 10 QOCG cases submitted by COA Region 3, five cases were substantiated.

COA Region 3: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3's documentation submission included a QOC training video and emails as evidence as to how COA Region 3 informs staff members about the importance of identifying and reporting QOCGs. 
- The policies and procedures noted a goal of closing 90 percent of QOCG cases within 90 days but did not indicate a time frame for acknowledging receipt of QOCGs. COA Region 3 staff members shared that their internal goal is to acknowledge each QOCG within 24 business hours of receipt. All 10 cases demonstrated COA Region 3's adherence to sending acknowledgement letters within 24 business hours and closing cases in less than 90 days. 
- Staff members shared that COA Region 3 moved to a more proactive approach to address potential grievances, coming from a place of education, before issues are escalated to a CAP. Due to the proactive approach, COA Region 3 staff members described a new process to meet with the provider/facility to address issues and provide education before initiating a CAP. COA Region 3 did not require a CAP for any of the 10 sample cases reviewed. 

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

HSAG found the following opportunities for improvement:

- Eight of the 10 sample cases reviewed were originally initiated by the member or the member's family; however, there was no documentation that the members received acknowledgment or resolution. COA Region 3 confirmed that the quality management (QM) department considers the staff member who submits the case to the QOC inbox as the originator of the concern and provides the acknowledgement and resolution letter to that staff member via email.
- COA Region 3's *Quality of Care Concerns* policy stated that the QM department may follow up with the member to determine if the member's immediate healthcare needs are being met. During the interview, COA Region 3 staff members indicated that if the case originates as a grievance, a care coordinator and/or grievance staff member may follow up with the member in real time. However, staff members stated that the QM department does not have any direct contact with the member. Although the QM department can see care coordination notes in the care management system, COA Region 3 did not have a policy or describe procedures for ensuring that appropriate member follow-up occurs. When submitting follow-up documents after the interview, COA Region 3 provided verification of member follow-up through care coordination system notes.
- COA Region 3's website includes information about how to file a grievance, an online submission form for submitting a grievance, and what the member can expect after filing a grievance. However, the website did not distinguish between a member grievance and a QOCG.
- The policies and procedures described case-specific reporting to the Department when the case is submitted to COA Region 3 by Department staff members; however, COA Region 3 did not submit or describe policies or procedures to inform the Department of receipt of a QOC or to submit a QOC summary as detailed in the MCE contract.

To address these opportunities, HSAG recommends that COA Region 3:

- Further define within the applicable policies and procedures its internal timeliness goals for acknowledging and investigating QOCGs.
- Establish clear follow-up processes to ensure that member follow-up is occurring to determine whether the member's immediate healthcare needs are being met, regardless of where the QOCG originates.
- Clearly define the number and/or severity of QOCGs needed to meet COA Region 3's threshold for escalating a provider/facility from tracking/trending to the next level of action required.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.

- Implement a process for notifying the Department that a QOCG has been received and expand its QOC summary process to include all QOCGs received, rather than just those referred by the Department.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023.

EPSDT Audit

Table 4-51 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-51—FY 2023–2024 EPSDT Audit Findings for COA Region 3

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	50%	75%
Post-Denial Record Review	92%	60%	77%

COA Region 3: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- Three medical necessity denials reviewed demonstrated the denials were due to a noncovered diagnosis. In each of these cases, the clinical documentation showed the noncovered diagnosis was the driving factor for the behavior, and each case was referred to care coordination to help the member and family access appropriate services.
- Multiple COA Region 3 policies outlined effective mechanisms to track referrals and ensure warm handoffs. Additionally, the review of the records found that COA Region 3 provided appropriate case coordination referrals and follow-up.
- All 15 non-utilizer sample members received at least one outreach attempt during the review period.

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

HSAG found the following opportunities for improvement:

- Within the records reviewed, there was no explicit documentation that the EPSDT definition of "medical necessity" was implemented.
- One COA Region 3 newsletter reviewed demonstrated that although EPSDT information was mentioned, the information was unclear and required revisions in the following months.
- Medical necessity denials reviewed documented that COA Region 3 UM staff members utilized InterQual criteria, which do not explicitly consider EPSDT within the review period. Additionally, none of the medical necessity cases reviewed included specific documentation of the consideration of the EPSDT definition of "medical necessity."
- COA Region 3's NABD template mostly followed the Department's template; however, COA Region 3's NABDs did not include the clinical criteria considered when making the denial determination.
- One denial case reviewed demonstrated that the member was not referred to care coordination to assist with finding placement and procuring EPSDT funding after an administrative denial for residential treatment due to a noncovered benefit.
- COA Region 3's well-visit IVR scripts detailed limited information within the voicemail message and did not include any EPSDT-specific information.
- Within the non-utilizer sample, three members did not receive a successful IVR outreach, and COA Region 3 conducted additional outreach to these members using the same IVR outreach modality. However, all subsequent attempts were unsuccessful.

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

- Strengthen its UM procedures to ensure the full EPSDT definition of "medical necessity" is considered during the review process.
- Strengthen its internal review procedures with clinical leadership and subject matter experts prior to distributing provider manuals.
- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to InterQual or ASAM, prior to issuing a denial.
- Update its NABDs to include UM criteria utilized to be in compliance with the CFR, CCR, and the Department's NABD template.
- Continue to improve processes and procedures to ensure members receive care coordination services, when appropriate.

- Work with the Department regarding what is considered successful/completed outreach.
- Consider sending a mailed letter to the member when additional IVR outreach is not successful/completed due to system errors.

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended COA Region 3:

- Ensure its CM staff members proactively offer assistance with scheduling appointments and transportation if the need is relevant to the member's situation. Furthermore, COA Region 3 may consider the addition of an EPSDT informational flyer in applicable NABD mailings to enhance member/family awareness of available services. Additionally, HSAG suggests the addition of member-specific assistance, next steps, and offering transportation when applicable to the member's situation.
- Add additional outreach in the form of a phone call to the requesting provider before or after the issuance of the notice of denial.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 EPSDT Recommendations

COA Region 3 reported addressing HSAG's recommendations by:

- Providing training to care management staff members on EPSDT from a partner organization, Family Voices, which included information on transportation benefits. Additionally, COA Region 3 plans on continuing annual training to staff members regarding EPSDT.
- Keeping strong communication channels between the provider network and UM staff members and enhancing notification of the NABD, as needed.

COA Region 3 still has the opportunity to consider the addition of adding an EPSDT informational flyer in applicable NABD mailings to enhance awareness of available services and adding member-specific information, assistance available, next steps, and offering transportation. COA Region 3's reported updates will likely demonstrate improvement to UM processes; however, COA Region 3 should continue to address the recommendations by HSAG to improve member communication, awareness, and ensure EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-52 displays the percentage of cases reviewed that HSAG's reviewers determined adhered to ASAM criteria.

Table 4-52—COA Region 3 Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
COA Region 3	40	35[1]	32	91%

[1] *Five samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 35.*

Table 4-53 presents the number of cases in the sample that HSAG reviewed for COA Region 3 and the percentage of cases in which HSAG's reviewers agreed with COA Region 3's denial determination.

Table 4-53—COA Region 3 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
COA Region 3	40	35[1]	34	97%

[1] *Five samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 35.*

COA Region 3: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 3:

- COA Region 3 used *The ASAM Criteria Navigator* from InterQual in some cases, which HSAG recognizes as a best practice.
- HSAG agreed with denial determinations in 97 percent of COA Region 3 sample cases.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making denial determinations.
- COA Region 3 did not send an NABD to the member when the denial was due to an administrative decision (e.g., late notification by the requesting provider). Additionally, in almost half of the cases reviewed, COA Region 3 did not send the NABD within the required time frame, and scores decreased from the previous review period.
- One of the denials in COA Region 3's sample was a case in which the member was eligible for EPSDT; however, COA Region 3 did not document any additional EPSDT considerations.

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

- Host training for providers and UM reviewers regarding the importance of considering the member's interdimensional interactions and co-occurring problems during the review process.
- Enhance monitoring mechanisms to ensure adherence to the required time frame for notifying the member of the denial determination.
- Include specific documentation in the UM system notes to demonstrate the review of EPSDT criteria for eligible members.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that COA Region 3:

- Update policies, procedures, and processes to ensure that members are notified of the denial determination and within the required time frame.
- Develop and use an NABD template to ensure that member communications regarding adverse benefit determinations include the full meaning of an acronym the first time it is used (e.g., substance use disorder [SUD], intensive outpatient [IOP], and American Society of Addiction Medicine [ASAM]) and to ensure that each of the required categories of information are included in the letter.

Assessment of COA Region 3's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

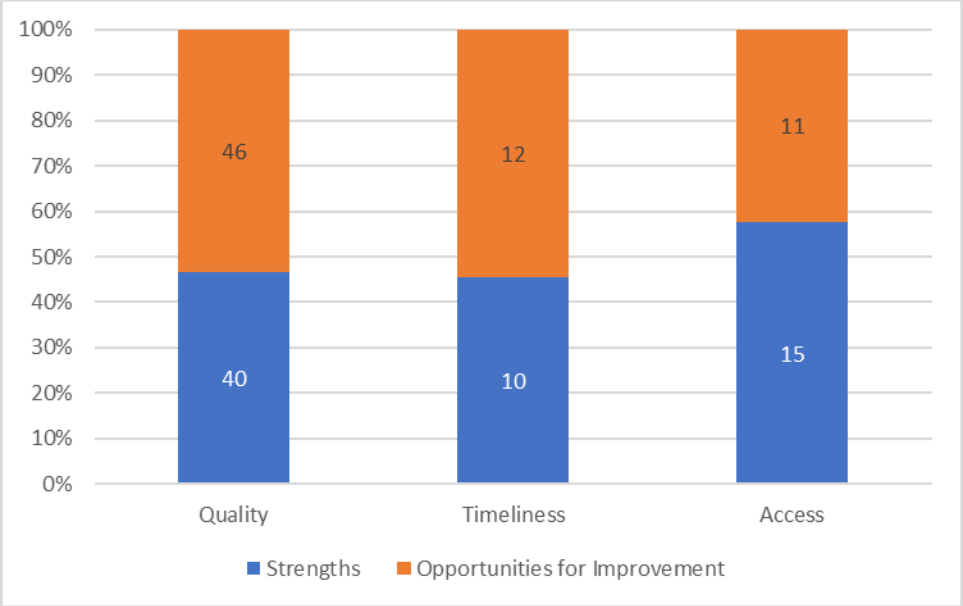
COA Region 3 reported addressing HSAG's recommendations by:

- COA UM auditing procedures including evaluating NABDs for acronym usage and will continue to direct staff to write out the full meaning for each instance.

HSAG anticipates COA Region 3's responses to the recommendations are likely to improve the communication between COA Region 3 and its members. However, COA Region 3 did not address the recommendation regarding timely notification of denials. COA Region 3 should continue addressing the recommendations made by HSAG for continuous improvement and quality management.

Region 4—Health Colorado, Inc.

Figure 4-4—Number of Strengths and Opportunities for Improvement by Care Domain for HCI*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

HCI submitted two PIPs for the 2023–2024 validation cycle. The clinical *Follow-Up After Emergency Department Visits for Substance Use [FUA]* PIP and the nonclinical *Social Determinants of Health (SDOH) Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. HCI resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 4-54 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUA*

Table 4-54—2023–2024 PIP Overall Confidence Levels for the *FUA* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
Resubmission	*Not Applicable*			*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUA* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. HCI received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-55—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	85%	100%	*Moderate Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. HCI received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUA*

Table 4-56 displays data for HCI's *FUA* PIP.

Table 4-56—Performance Indicator Results for the *FUA* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of ED visits for members ages 13 years and older with a principal	N: 410	26.1%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.	D: 1,573						

N–Numerator D–Denominator

For the baseline measurement period, HCI reported that 26.1 percent of ED visits for members ages 13 years and older who had a principal diagnosis of SUD or other diagnosis of drug overdose had a follow-up visit within seven days of an ED visit.

Nonclinical PIP: *SDOH Screening*

Table 4-57 displays data for HCI's *SDOH Screening* PIP.

Table 4-57—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of members with at least one BH service who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	N: 931 D: 31,955	2.91%					

N–Numerator D–Denominator

For the baseline measurement period, HCI reported that 2.91 percent of members with at least one BH service were screened for the four SDOH domains.

Interventions

Clinical PIP: *FUA*

Table 4-58 displays the barriers and interventions documented by the health plan for the *FUA* PIP.

Table 4-58—Barriers and Interventions for the *FUA* PIP

Barriers	Interventions
Loss of referral application.	Revise BH referral mechanism.
Pre-contemplative/contemplative member.	Peer specialist on-site in ED.

Barriers	Interventions
Nonstandard messaging on intervention and referral.	Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
Social needs/lack of knowledge.	Care coordination/care navigator on-site in ED.
Physician preference/lack of knowledge.	Medication-Assisted Treatment (MAT) training/protocols.

Nonclinical PIP: *SDOH Screening*

Table 4-59 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-59—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
• Absence of data visibility on outreach volume. • Competing priorities for care coordination workload.	Outreach monitoring and feedback.

HCI: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for HCI:

- HCI followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- HCI reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

HCI: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. HCI addressed all validation criteria and received validation ratings of High Confidence for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and HCI received *High Confidence* for the final Module 4 submission. HCI's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-60 shows the performance measure results for HCI for MY 2021 through MY 2023.

Table 4-60—Performance Measure Results for HCI

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	48.51%	53.16%	58.80%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	70.43%	46.26%	69.57%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	36.49%	28.84%	36.07%	40.14%
Follow-Up After a Positive Depression Screen	50.19%	40.86%	37.80%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	33.11%	14.88%	36.59%	36.42%

HCI: Strengths

The following performance measure rates for MY 2023 increased from the previous year for HCI:

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

Additionally, the following performance measure rate for MY 2023 exceeded the performance measure target:

- *Behavioral Health Screening or Assessment for Children in the Foster Care System*

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

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

- *Engagement in Outpatient SUD Treatment*

- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*
- *Follow-Up After a Positive Depression Screen*

To address these opportunities for improvement, HSAG recommends HCI:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[28]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended HCI:

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

Assessment of HCI's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

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

- A partnership with Carelon's Data, Analytics, & Reporting team to leverage any opportunity regarding completeness and timeliness of data on the performance measures that HCI calculates performance on during the year (i.e., BHIP measures). Previous performance measure dashboards reported scores on these measures following a full 90-day claim lag period from the end of the reference month. The analysis of claims and encounters revealed that greater than 96 percent of claims and encounters are received within 30 days of service. Following consultation with clinical leadership and quality subject matter experts, the performance measure dashboards were amended to report performance at the earliest possible opportunity (i.e., 30-day claim lag). In a parallel project, HCI reported that it entered an agreement to use the Cotiviti-Medical Intelligence application to provide more current performance measure data performance than available through Data Analytics Portal (DAP) from the State. This certified HEDIS engine provides actionable reporting, and HCI is currently reviewing how to best integrate these reports with current reporting dashboards.
- Providing education to its care coordination entities on how to best use the ADT roster that is sent to each entity daily informing them of assigned members who have been seen in the inpatient setting or ED. Additionally, an initiative for the data from these ADT rosters to be imported into the care

[28] Ibid.

coordination documentation system (Essette) used by all entities was launched so that historical records of these critical transitions of care (including details on dates, facility, diagnoses) are available to inform appropriate care plan development. HCI is also exploring connections between this programming with the Hospital Transformation Program (HTP). HCI is working to revise the current ADT notification to not only augment this list with actionable data from the HTP feeds, but also to prioritize members for outreach based on clinical factors.

HSAG recognizes that HCI's enhancement of its dashboard to provide more actionable data and its work with hospitals to receive notifications of members who need care coordination are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

HCI Overall Evaluation

Table 4-61 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-61—Summary of HCI Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	12	3	1	0	75%v
IX. Subcontractual Relationships and Delegation	4	4	2	1	1	0	50%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**48**	**4**	**2**	**0**	**89%**

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

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

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

~ *Indicates no change from review three years prior.*

HCI: Trended Performance for Compliance With Regulations

Table 4-62 presents, for all standards, the overall percentage of compliance score for HCI for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-62—Compliance With Regulations—Trended Performance for HCI

Standard and Applicable Review Years	HCI Average—Previous Review	HCI Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	97%	94%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	94%	86%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	82%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**86%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	83%	91%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**94%**	**75%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	94%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**75%**	**50%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	88%	86%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, HCI demonstrated moderate to high-achieving scores from the previous review cycle for two standards, one of which maintained 100 percent compliance, and the other increased from 86 percent to 100 percent compliance, indicating a strong understanding of most federal and State regulations. The scores for both Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation declined from the previous review cycle with the most notable decrease of 25 percentage points for Standard IX—Subcontractual Relationships and Delegation.

HCI: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for HCI:

- HCI provided health education via text, email, and IVR modalities designed to increase member understanding about the RAE's benefits and requirements.

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

HSAG found the following opportunities for improvement:

- Carelon's credentialing policy did not include required language indicating that it does not discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- Policies and procedures did not state that Carelon would not knowingly employ any staff members who are "suspended" from federal participation.
- The provider agreement did not include required language stating that HCI does not prohibit or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member.
- Written subcontractor delegation agreements did not include all federally required language.
- HCI was unable to describe its role in leading the compliance program nor in any oversight and monitoring of Carelon's compliance activities.
- The delegation agreement between HCI and Carelon did not include the standard to which Carelon was held nor the frequency, methodology, and periodicity for conducting the ongoing monitoring.

To address these opportunities for improvement, HSAG recommends HCI:

- Determine what accommodation for people with disabilities may be included in a BH setting and incorporate these accommodations into the provider directory filters.
- Revise its policies to include language that states that Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Update its policies to include the terms "excluded," "suspended," and "debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (i.e., an individual owning 5 percent or more of the contractor's equity) who is debarred,

suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulations or Executive Order 12549.

- Modify the PCMP agreement to include language stating that HCI does not prohibit, or otherwise restrict, healthcare professionals acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient.
- Strengthen its compliance program to ensure that the compliance officer, leadership team, and compliance committee develop the compliance plan and strategic goals for its RAE.
- Have direct oversight and evidence of ongoing monitoring performed by HCI of any delegated activities pertaining to 42 CFR §438, per State and federal requirements.
- Revise or amend the written agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended HCI:

- Enhance its procedures and monitoring to ensure that all denial decisions are made within time frame requirements.
- Correct timely appointment standards in the PCP Practitioner Agreement.
- Develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare.
- Revise documents that stated that members must follow a verbal appeal request with a written request.
- Update the appeal policy to include that the coordinator will make reasonable efforts to notify the member of the delay if the delay is in the member's best interest.

Assessment of HCI's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, HCI updated its Medical Necessity Determination Timelines policy and other supporting documentation to clarify that the denial decision time frame is based on the date of the service request until the deadline. HCI made corrections to the timely appointment standards in the PCP Practitioner Agreement. HCI conducted health equity roundtable discussions that included education and training opportunities and other discussion related to best practices for health equity. The requirement that the member must follow a verbal appeal request with a written request was removed from documents. In addition, staff members were made aware of updated documentation. Lastly, HCI revised its appeal policy to add that the coordinator will make reasonable efforts to notify the member of the delay if the delay is in the member's best interest. HSAG recognizes that updating supporting documentation with corrected time frames, member notice procedures, member letter content, and ongoing monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

HCI: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for HCI:

- HCI met the minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP,CNS) and Family Practitioner (MD, DO, NP, CNS) in all contracted counties.
- HCI performed well in the BH network category, meeting all minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.
- HCI met the minimum network requirements for General and Pediatric SUD Treatment Practitioner in 94.7 percent of the contracted counties.
- HCI established robust processes to keep provider data up to date and accurate through its quarterly attestation reminders to providers and annual provider directory attestation requirement, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.
- HCI established robust processes to maintain data accuracy by frequently performing internal audits of a representative sample of updated member and provider records, wherein audits were conducted at a 100 percent rate for new employees and reduced as accuracy goals were met.

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

HSAG found the following opportunities for improvement:

- HCI did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties.
- HCI did not meet the minimum network requirements for SUD Treatment Facilities–ASAM LOC 3.3 in all contracted counties, and 89 percent or more of the contracted counties did not meet the minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.7 and 3.7 WM.
- HCI used the daily and monthly 834 files for member demographic data, but up to 8 percent of members on the enrollment files did not have a physical address on the file.

To address these opportunities for improvement, HSAG recommends HCI:

- Conduct an in-depth review of provider categories for which HCI did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Inquire with the Department regarding whether it should pursue other sources of address information for its members to ensure completeness of its member data used for network adequacy reporting.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that HCI continue to conduct an in-depth review of provider categories for which HCI did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that HCI:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, HCI should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the HCI data that could not be located in the online provider directory.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of HCI's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Continued to survey the provider landscape to ensure any new facility will be contracted to provide services to the members in need. HCI is willing to contract with any eligible provider. HCI has worked with providers in its network to expand its services and contract for any HIOP services, which helps with access. HCI has targeted providers who are not in its network that offer HIOP services to bring into its network.
- Due to the lack of facilities in the contracted area, HCI works with members and offers care coordination if necessary. HCI additionally works with members and providers to coordinate single case agreements, to ensure members receive the appropriate LOC.

- Continued to ensure the provider data are accurate through one-on-one meetings with providers and by requesting updated address information through roster updates.

Based on the above response, HCI worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-63 presents HCI's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-63—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for HCI

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	99.3%	99.3%
Diagnosis Code	92.0%	99.3%	97.1%
Place of Service	NA	85.4%	99.3%
Service Category Modifier	NA	100.0%	99.3%
Units	NA	99.3%	99.3%
Revenue Code	100.0%	NA	NA
Discharge Status	95.6%	NA	NA
Service Start Date	100.0%	100.0%	99.3%
Service End Date	99.3%	100.0%	99.3%
Population	NA	100.0%	99.3%
Duration	NA	99.3%	99.3%
Staff Requirement	NA	100.0%	99.3%

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

Table 4-64 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with HCI's EDV results for each of the validated data elements.

Table 4-64—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for HCI

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Procedure Code	NA	90.0%	100.0%
Diagnosis Code	100.0%	100.0%	100.0%

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

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

HCI: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for HCI:

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

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in HCI's EDV results, HCI's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with an 85.4 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends HCI:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended HCI consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers and reviewers.

Assessment of HCI's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

HCI reported implementing training for providers on the RAE 411 audit, service categories, and common areas of concern. Additionally, HCI reported performing additional checks and balances to ensure accuracy of received data.

Based on HCI's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

HCI: Adult CAHPS

Table 4-65 shows the adult CAHPS results for HCI for FY 2021–2022 through FY 2023–2024.

Table 4-65—Adult CAHPS Results for HCI

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	56.96%	54.55%	58.86%
Rating of All Health Care	52.43%	47.86%	53.92%
Rating of Personal Doctor	66.67%	62.68%	66.13%
Rating of Specialist Seen Most Often	65.57%$^{+}$	62.35%$^{+}$	53.13%$^{+}$ ↓
Getting Needed Care	86.11%$^{+}$	81.28%	76.68%$^{+}$
Getting Care Quickly	86.85%$^{+}$	81.22%$^{+}$	81.20%$^{+}$
How Well Doctors Communicate	92.76%	94.08%	91.93%$^{+}$
Customer Service	90.00%$^{+}$	95.15%$^{+}$	81.71%$^{+}$ ▼
Coordination of Care	80.00%$^{+}$	76.81%$^{+}$	77.78%$^{+}$
Advising Smokers and Tobacco Users to Quit	60.53%$^{+}$	51.69%$^{+}$	53.19%$^{+}$ ↓

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Discussing Cessation Medications	35.00%+	32.61%+	38.30%+ ↓
Discussing Cessation Strategies	36.84%+	35.56%+	40.22%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

HCI: Strengths

The following measure's FY 2023–2024 score for HCI was higher, although not statistically significantly, than the 2023 NCQA national average:

- *Getting Care Quickly*

The following measures' FY 2023–2024 scores for HCI were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Coordination of Care*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

The following measures' FY 2023–2024 scores for HCI were statistically significantly lower than the 2023 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*

The following measure's FY 2023–2024 score for HCI was statistically significantly lower than the FY 2022–2023 score:

- *Customer Service*

To address these low CAHPS scores, HSAG recommends HCI consider:

- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with members. Specialists could ask questions about members' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their condition and the actions they will take to monitor and manage members' conditions in the future, as well as follow up with any concerns that members might have about their healthcare.
- Providing internal training sessions and sending out newsletters designed to educate providers on the importance of guiding and advising smokers and tobacco users to quit. The training could emphasize the importance of doctors speaking directly to their members about quitting. It can provide information and advice on speaking to members about potential long-term health implications related to tobacco use, medications and strategies for tobacco cessation, and educating the patients on long-term health outcomes if they continue tobacco use versus tobacco cessation.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset patient, providing solutions, or making amends for problems that the patient reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

HCI: General Child CAHPS

Table 4-66 shows the general child CAHPS results for HCI for FY 2021–2022 through FY 2023–2024.

Table 4-66—General Child CAHPS Results for HCI

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	67.93%	69.64%	66.86%
Rating of All Health Care	56.78%	68.89%	65.29%
Rating of Personal Doctor	74.00%	67.20%	73.79%
Rating of Specialist Seen Most Often	78.57%$^{+}$	82.61%$^{+}$	70.83%$^{+}$
Getting Needed Care	81.62%$^{+}$	84.95%$^{+}$	84.74%$^{+}$

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Getting Care Quickly	84.47%+	88.43%+	87.05%+
How Well Doctors Communicate	95.91%	96.44%	92.96%
Customer Service	82.00%+	93.06%+	85.19%+
Coordination of Care	84.44%+	80.65%+	80.49%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

HCI: Strengths

The following measures' FY 2023–2024 scores for HCI were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measure's FY 2023–2024 score for HCI was higher, although not statistically significantly, than the FY 2022–2023 score:

- *Rating of Personal Doctor*

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

The following measures' FY 2023–2024 scores for HCI were lower, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*

The following measures' FY 2023–2024 scores for HCI were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends HCI consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.
- Obtaining feedback from parents/caretakers of child members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Involving staff members at every level to assist in improving parents'/caretakers' of child members experiences.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child members perspectives. Physicians could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers.

- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker of the child member, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage the parent/caretaker of the child member to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, HCI reported engaging in the following QI initiatives:

- Efforts were aligned with the CDPHE to enhance its smoking cessation tip sheet, which outlined the Colorado QuitLine benefits. The tip sheet included Prenatal Plus information for pregnant members and "My Life My Quit" information for its teen members. Additionally, HCI had a "teen-friendly" information sheet with a QR code that linked to "My Life My Quit." These resources were available in both English and Spanish on HCI's website.
- A specific teen sheet on vaping, which focused on smoking cessation efforts, was promoted. HCI sent a text to members: "Health Colorado: Did you know that Medicaid has a free program to help members 12 and older quit smoking? Visit bit.ly/CO_Quitline for more info. Text STOP to stop; HELP for help."
- Training around the smoking cessation assessment was built and added to its care coordination subcommittee meeting. The smoking cessation assessment could be used with any member that received care coordination services. It contained a pregnancy-specific question and assessed for the frequency and volume of a member's tobacco use, past quitting attempts, current willingness to quit, barriers, and support. The assessment connected members to resources supporting their quitting efforts. The training was recorded and posted in the HCI care coordination training hub for ongoing access and training availability. Smoking cessation resources were also added into its platform for care coordinators to use when working with members at any time.
- Additional education around the importance of advising and referring members to smoking cessation programs was provided. HCI facilitated a training for BH and PH providers at a provider roundtable. HCI's goals for the training were aimed at educating healthcare professionals on the Colorado QuitLine and boosting awareness and utilization of the Colorado QuitLine. In addition, the care coordination subcommittee meeting included a presentation on the Colorado QuitLine.
- The objective for the reporting period to connect members to the Colorado QuitLine was met by sending a targeted text campaign to 10,820 identified members with a smoking indicator. The

content of the text message was: "Health Colorado: Did you know that Medicaid has a free program for members 12 and older to help quit smoking? Visit bit.ly/CO_Quitline for more info."

- Data provided by CDPHE around members enrolled in the Colorado Quitline were obtained and analyzed.
- HCI concentrated its prevention and wellness efforts on smoking cessation. During its "Getting Started" webinar, a representative from the Colorado QuitLine presented on smoking cessation and the Colorado QuitLine programs. Eight members attended the presentation, which HCI posted in both video and PDF format on its website. Information on the Colorado QuitLine was also posted on HCI's social media accounts. The Colorado QuitLine tip sheets were given to the PT team to share with PCMPs and mental health providers. Also, HCI hosted CDPHE's tobacco cessation intervention coordinator, who provided an overview of the Colorado QuitLine program.
- Health information sheets were distributed to healthcare professionals who work with members, including care coordinators, PT coaches, and providers.
- Information about smoking cessation resources was included in provider newsletters.
- Communication at community meetings was focused on smoking cessation, and members were referred to the website for smoking cessation resources.
- During the care coordination meeting in the month of December, care coordinators were given the wellness and prevention focus, which was smoking cessation. The latest tip sheets for the Colorado QuitLine and teen vaping were distributed to care coordinators during that meeting.

Assessment of HCI's Approach to Addressing FY 2022–2023 CAHPS Recommendations

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

QUIP

HCI did not identify any scores under the 90 percent accuracy threshold during the FY 2022–2023 EDV and was therefore exempt from the QUIP.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that HCI maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of HCI's Approach to Addressing FY 2022–2023 QUIP Recommendations

HCI reported the decision to not take further action regarding recommendations due to overall low sample size and minimal areas of disagreement scores that were based on HCI staff member training needs regarding the USCS, not provider-focused opportunities. HSAG recognizes that while no additional action was needed from the provider, HCI has the opportunity to continue monitoring and ensure regular trainings for its internal staff members to maintain accurate auditing practices.

Mental Health Parity Audit

Table 4-67 displays the MHP Audit compliance scores for HCI for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-67—FY 2023–2024 MHP Audit Score for HCI

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
HCI	4	92%	Inpatient	97%	96%^
			Outpatient	95%	

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

HCI: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for HCI:

- HCI demonstrated an overall score of 96 percent.

- HCI's delegated UM vendor, Carelon, required its UM staff members to pass IRR testing annually with a minimum score of 90 percent, which was a 10 percent increase in the minimum score compared to the last review period (CY 2022).
- Carelon used nationally recognized UR criteria (InterQual or ASAM) and documented which criteria it used for all denial determinations.
- In all cases reviewed, HSAG also found that Carelon followed its policies and procedures related to which services require prior authorization.
- Carelon notified providers of the denial determinations by telephone or secure email and provided a copy of the NABD within the required time frame for all records reviewed except one.
- The denial determination was made by a qualified clinician in all cases reviewed.
- In all applicable cases, the records contained evidence that a peer-to-peer review was offered to the requesting provider.
- Most records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system.
- The NABDs contained the required information, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from HCI in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative LOC, if applicable. Additionally, the inpatient SUD NABDs included the required language regarding how each ASAM dimension was considered when determining medical necessity.
- During the MHP interview, Carelon staff members reported hiring a new staff member to lead the process for reviewing IAs for qualified residential treatment program placements. The new staff member would provide additional support and assistance to UM and care management staff members, including working with the parent/guardian and obtaining additional information. Additionally, Carelon brought on a dedicated MD for the Colorado contract for UR who specifically understands Colorado regulations and standards.

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

HSAG found the following opportunities for improvement:

- In some cases, Carelon did not notify the provider of the denial determination or send the NABD to the member within the required time frame.

- Within one case, the reason for the denial in the UM system was not consistent with the reason the member was provided in the NABD.
- In one record reviewed, Carelon did not reach out to the requesting provider for additional documentation to determine medical necessity.

To address these opportunities for improvement, HSAG recommends HCI:

- Enhance Carelon's monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.
- Provide continuous and regular staff member training to ensure that the reason for the denial in the UM system is consistent with the reason the member was provided in the NABD.
- Enhance monitoring procedures to ensure that additional outreach occurs with the requesting providers when adequate documentation is not received.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended HCI:

- Periodically train and conduct record audits to ensure that UM staff members are correctly identifying and documenting denial reasons within the UM system.
- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.
- Provide continuous and regular training for UM staff to ensure that NABDs are written at an easy-to-understand reading grade level. Additionally, should Beacon use any medical terminology, HSAG recommends including a plain language explanation next to any medical terminology.
- As a best practice, update applicable UM documents and policies and procedures to outline the required ASAM language within inpatient and residential SUD NABDs.

Assessment of HCI's Approach to Addressing FY 2022–2023 MHP Recommendations

HCI reported addressing HSAG's recommendations by:

- Training UM staff members on required time frames and meeting internally with the letters team to improve turnaround time compliance with sending NABD's to members and providers. Additionally, HCI reported creating a weekly report to provide oversight of turnaround time.
- Discussing with internal staff members reliability within the NABDs to ensure narratives are easy to understand for members.

HCI still has the opportunity to continue addressing HSAG's recommendations of providing continuous staff training to ensure the reason for the denial in the UM system is consistent with the reason the

member was provided within the NABD and enhancing monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame. HSAG anticipates HCI's responses are likely to demonstrate improvement to overall UM processes. HCI should continue to address the recommendations made by HSAG to increase MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, Carelon investigated nine potential QOCG cases on behalf of HCI. HCI's average membership in CY 2023 was 147,327, with 127,959 members enrolled as of December 31, 2023. Of the nine QOCG cases investigated by Carelon, no cases were substantiated.

HCI: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for HCI:

- All potential QOCGs are reviewed by the Quality-of-Care Committee. Staff members from both Carelon and HCI comprised the committee, which determines whether the QOCG is designated *Founded*, *Unfounded*, or *Unable to Determine*.
- Carelon and HCI staff members verified that no CAPs were issued during the CY 2023 review period; nevertheless, Carelon staff members further described the CAP procedures outlined in the policies and procedures, including how the Quality Connect system monitors the CAPs and how all communication regarding the CAP is documented in the system.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- Carelon verified that cases aside from those originating as member complaints or grievances did not receive follow-up. They also noted that generally follow-up directly with the members is not necessary, as members have discontinued services by the time the QOCG is reported.
- Based on instruction from a previous Department employee, HCI sends quarterly reports to the Department only detailing cases with the determination of *Founded*.
- Two cases were submitted by an employee on behalf of the members. In one case, the member received an acknowledgement letter within two days and a resolution letter within 15 days of receipt of the QOCG. In the other case, the member received an acknowledgement letter within two days of receipt of the QOCG; however, the resolution letter was not sent to the member until 20 days after receipt of the QOCG.

To address these opportunities, HSAG recommends that HCI:

- Consider revision of the definition of "Unfounded" as it currently dismisses any QOCG that occurred if the provider "lacked knowledge" or was "not able to act" in a way to successfully avoid the potential QOCG for the member. The current definition may inadvertently dismiss QOCGs where provider training and education could be beneficial.
- Establish a clear process to ensure that member follow-up is occurring to determine whether the member's immediate healthcare needs are being met, regardless of where the QOCG originates.
- Implement a process for notifying the Department that a QOCG has been received and include submission of a QOC summary for all cases, as outlined in the MCE contract.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023; however, HCI reported ongoing QI efforts to address the FY 2021–2022 recommendations.

Assessment of HCI's Approach to Addressing FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

HCI reported addressing HSAG's recommendations by:

- Assessing whether the incident qualifies as a potential QOCG. This determination is made using CMS' definition of a potential QOCG as "a type of grievance that is related to whether the quality of covered services provided by the health plan or provider meets professionally recognized standards of health care including whether appropriate health care services have been provided or have been provided in appropriate settings." Investigations into potential QOCG concerns are conducted by the Quality Management Department, and the findings are evaluated by the Quality-of-Care Committee for appropriate follow-up, corrective actions, and monitoring. The Quality-of-Care Committee meets every other Tuesday, up to three times per month, an increase from the previous year.
- Clarifying that providers, HCI staff, or other concerned parties can report potential QOCG issues through an adverse incident reporting form, which can be submitted to the Quality Management Department via a designated email address or a confidential secure fax. The adverse incident form is available on the RAE website and is provided digitally to providers upon their request. Providers are informed of the reporting process at quarterly documentation training events and through mass distribution emails at least twice per year.
- Documenting all potential QOCGs and presenting them to the Quality-of-Care Committee, which reviews the investigation and determines the findings based on the facts of each case. Corrective actions are tracked and monitored until closure. The reporting, investigation, and tracking of potential QOCGs by the Quality Management Department are reported to the Department quarterly, as required. Policies and procedures, along with workflows, are updated to comply with contract requirements, as necessary.

HSAG anticipates HCI's responses to the recommendations have a moderate likelihood to improve overall processes and increase HCI's understanding and implementation of the Colorado-specific QOCG process. HCI should continue addressing the recommendations made by HSAG for continuous improvement.

EPSDT Audit

Table 4-68 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-68—FY 2023–2024 EPSDT Audit Findings for HCI

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	25%	63%
Post-Denial Record Review	83%	33%	58%

HCI: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for HCI:

- HCI submitted extensive evidence to demonstrate its adherence to its EPSDT policy and completed the required provider training during the review period. Additionally, regular provider newsletters were distributed during the review period.
- Evidence submitted by HCI demonstrated its adherence to the EPSDT policy and in its Annual EPSDT Outreach Strategic Plan that education and training is completed annually and additional training, oversight, and feedback occurs consistently throughout the year.
- HCI's procedure to seek feedback regarding outreach from the Member Experience Advisory Council (MEAC) was determined to be a best practice. Furthermore, HCI reported that members preferred to received text messages rather than emails.
- HCI was one of two MCEs with reported mechanisms to track returned mail rates.

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

HSAG found the following opportunities for improvement:

- Carelon did not have a consistent process to clearly document a secondary review, in addition to InterQual or ASAM, was conducted for EPSDT members prior to issuing a denial.
- The denial samples reviewed showed that HCI did not send an NABD to members regarding their denial in four of the 15 samples, all of which were administrative denials.
- A care coordination assessment given to the member included a decision point for Carelon care coordination staff members to assess whether they think it is beneficial to continue the assessment, which seemed to limit completion of the full assessment and the opportunity for the member/parent/guardian to identify additional healthcare needs.
- Carelon staff members shared that outreach efforts to the non-utilizer members within the sample were minimal and revealed less outreach than expected from its vendor. Of the 15 non-utilizer records reviewed, HCI attempted annual outreach for only five records.

To address these opportunities for improvement, HSAG recommends HCI:

- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to InterQual or ASAM, prior to issuing a denial.
- Update its UM procedures to include administrative denials (any denial, in whole or in part, of payment for a service that involves anything other than a clean claims issue) to ensure members are informed of decisions about their healthcare and informed of appeal rights.
- Review and further adapt its assessment tools to ensure the member/parent/guardian has ample opportunity to communicate any healthcare needs.
- Perform quality checks both internally and with the texting vendor to ensure consistent outreach is occurring to the non-utilizer members including when the first outreach attempt is unsuccessful.

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended HCI:

- Discuss with the Department whether voicemails may be considered completed outreach.
- Develop a desktop procedure that outlines how HCI works with the Department to obtain EPSDT services for members, when necessary.

Assessment of HCI's Approach to Addressing FY 2022–2023 EPSDT Recommendations

HCI reported addressing HSAG's recommendations by:

- Developing an EPSDT referral process and RAE care coordination template. The template documents the procedures for HCI's UM team to follow in obtaining EPSDT services for members.
- Expanding documenting in its EHR to demonstrate that UM staff considered the member's needs, environment, and how to assist the member in achieving or maintaining maximum functional capacity.
- Creating an EPSDT documentation template for the UM staff members to serve as a guide for noting medical necessity considerations for EPSDT members. Additionally, the template serves as a reminder to UM managers to record when referrals for care coordination have been completed.
- Conducting several EPSDT trainings during Provider Roundtable sessions and with UM and call center staff members.

HCI still has the opportunity to address HSAG's recommendation of discussing with the Department whether voicemails may be considered completed outreach. HCI's responses to the recommendations are likely to improve UM processes. HCI should continue to address the recommendations by HSAG to ensure member awareness and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-69 presents the number of cases in the sample that HSAG reviewed for HCI and the percentage of cases in which HSAG's reviewers agreed with HCI's denial determination.

Table 4-69—HCI Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
HCI	92	83[1]	62	75%

[1] *Nine samples were administrative denials and were not applicable for medical necessity review; therefore, the total applicable sample is 83.*

HCI: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found that while HCI did not exceed minimum expectations, it demonstrated improvement from the previous review period regarding sending the member an NABD after the denial decision and followed standard best practices including using a two-step review process that included UM staff members with appropriate credentials.

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

HSAG found the following opportunities for improvement:

- Almost half of the NABDs sent by HCI were untimely.
- Sample cases for HCI included one EPSDT eligible member; however, HCI did not document any additional EPSDT considerations.
- The sample cases for HCI included 15 Special Connections cases. Of those 15 cases, 11 were medical necessity reviews. HSAG's reviewers disagreed with the selection and implementation of ASAM criteria in all 11 of the Special Connections sample cases that were reviewed for medical necessity.
- Although it is best practice for facilities to begin discharge planning upon the member's admission, many cases demonstrated a delay in discharge planning, resulting in members being denied additional coverage without a stable discharge plan, which increased relapse risk.
- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations.
- In many cases, UM reviewers justified denial of 3.1 and 3.5 LOCs by stating that members were stabilized in dimensions 1–3; however, stabilization in those dimensions is an admissions requirement for these levels.

To address these opportunities for improvement, HSAG recommends HCI:

- Enhance monitoring mechanisms to ensure adherence to the required time frame for notifying the member of the denial determination.
- Host training for providers and UM reviewers regarding the importance of considering the member's interdimensional interactions and co-occurring problems during the review process.
- Provide additional training for providers and require additional documentation from both the requesting provider and the UM staff members regarding the incorporation of the *Dimensional Considerations for Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children*[29] into their determination due to increased risk for members and their dependents. When training, HCI should place additional emphasis on the importance of provider documentation regarding Special Connections members and considerations made by UM staff members.
- Include specific documentation in the UM system notes to demonstrate the review of EPSDT criteria for eligible members.

[29] Mee-Lee D, Shulman GD, Fishman MJ, et al., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. American Society of Addiction Medicine; 2013: 17.

- Provide additional training for providers regarding discharge planning as well as using care coordination and other available resources to provide assistance with discharge planning and continuity of care.
- Provide additional training to UM reviewers regarding appropriate criteria for LOCs, specifically how UM reviewers should consider dimensions 4–6 when making determinations for residential LOCs.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that HCI:

- Update its policies, procedures, and processes to ensure that sufficient clinical documentation is received and included in each service authorization file to support the authorization approval or denial.
- Update policies, procedures, and processes to ensure that members receive an NABD when required.

Assessment of HCI's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

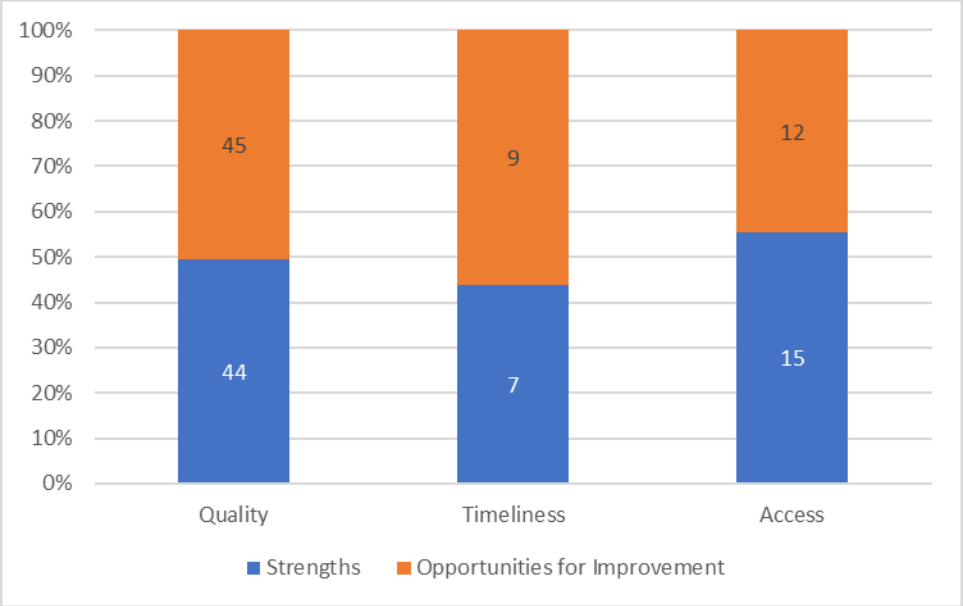
HCI reported addressing HSAG's recommendations by:

- Completing a UM training regarding clearer documentation of administrative denial reasons, documentation of peer-to-peer reconsiderations, and SUD UM turnaround times.
- Providing additional training for UM staff members to include more specific language in ASAM documentation, continued stay and discharge criteria, special populations, as well as incorporating the members' progress on their treatment goals into documentation.
- Internally revising language used for medically necessary denials to include more detail and full ASAM criteria that were not met.
- HCI's UM team attending an ASAM training provided by the Department.
- Onboarding a dedicated medical director to help ensure consistency in review determinations.

HCI still has the opportunity to continue addressing HSAG's recommendations of updating policies, procedures, and processes to ensure that members receive an NABD when required. HCI should continue to address the recommendations made by HSAG to improve the process of making SUD UM determinations and communicating appropriately with its members.

Region 5—Colorado Access

Figure 4-5—Number of Strengths and Opportunities for Improvement by Care Domain for COA Region 5*



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

The following are COA Region 5's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment related to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

COA Region 5 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP and the nonclinical *Social Determinants of Health (SDOH) Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. COA Region 5 resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 4-70 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUH*

Table 4-70—2023–2024 PIP Overall Confidence Levels for the *FUH* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUH* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA Region 5 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-71—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	75%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA Region 5 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUH*

Table 4-72 displays data for COA Region 5's *FUH* PIP.

Table 4-72—Performance Indicator Results for the *FUH* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of	N: 476	36.96%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	D: 1,288						

N–Numerator D–Denominator

For the baseline measurement period, COA Region 5 reported that the percentage of 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 was 36.96 percent.

Nonclinical PIP: *SDOH Screening*

Table 4-73 displays data for COA Region 5's *SDOH Screening* PIP.

Table 4-73—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of Region 5 members who were screened for SDOH using the Core 5 SDOH screening tool.	N: 0 D: 2,170	0%					

N–Numerator D–Denominator

For the baseline measurement period, COA Region 5 reported that 0 percent of Region 5 members were screened for SDOH using the Core 5 SDOH screening tool.

Interventions

Clinical PIP: *FUH*

Table 4-74 displays the barriers and interventions documented by the health plan for the *FUH* PIP.

Table 4-74—Barriers and Interventions for the *FUH* PIP

Barriers	Interventions
Care manager challenges with the existing member outreach process due to the following barriers: • Volume of work is too high • Intervention does not feel meaningful • Not enough time to serve members with complex needs • High administrative burden for high volume of members	**Colorado Access care coordination for members with inpatient mental health admissions:** Colorado Access' BH program has been streamlined to improve the member outreach process. Care managers coordinate care with providers, connect members with appropriate outpatient BH services, and mitigate barriers to discharge or engagement in follow-up services. The new approach stratifies members by risk level to reduce overall volume of admissions and to provide an additional touchpoint to members in the seven days following discharge to promote successful follow-up appointment attendance.
• Community Mental Health Centers (CMHCs) not being notified when a member had an inpatient hospital admission, and having difficulty identifying members who needed a follow-up appointment after discharge. • Hospitals have difficulty identifying members who were already engaged in BH services with a CMHC or other BH provider, so they did not know where to get a member connected for a follow-up appointment.	**Hospital, CMHCs, and Care Management seven-day follow-up dashboard:** Colorado Access worked to build a system that connects hospitals, CMHCs, and our internal care management team to coordinate discharge planning. Colorado Access has implemented a multi-faceted dashboard that hospitals, CMHCs, and the Colorado Access Care Management team can utilize to connect discharged members to BH providers in real-time. CMHCs can now access this dashboard system to see where their members are hospitalized in real-time and preemptively coordinate a follow-up appointment after discharge. They can also see their seven-day follow-up performance rate in real-time. Additionally, hospitals can now see which members are already connected to CMHCs so they can coordinate more targeted discharge and access other BH outpatient options besides CMHCs if appointment availability is limited within the seven-day time frame. This intervention will build community partnerships between hospitals and outpatient BH providers.
CMHCs need for more financial support and incentive to dedicate resources and staffing for 7-day follow-up rate improvement efforts.	**New Value-Based Payment Model for CMHCs:** Colorado Access recently enacted a new value-based payment model for the seven-day follow-up after hospitalization for mental illness metric to all CMHCs. If this *FUH* metric improves, CMHCs will receive additional payment.

Nonclinical PIP: *SDOH Screening*

Table 4-75 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-75—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Existing care management scripts ask members a variety of SDOH questions that do not cover all 5 SDOH core domains.	Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable care management scripts.
The internal Colorado Access HealthEdge GuidingCare system has not been updated since 2021. The older system has impacted the ability to update the care management scripts and workflows within the GuidingCare system in a timely manner.	**Optimization of the collection of SDOH data and reporting within HealthEdge GuidingCare.** The updated and upgraded GuidingCare system incorporates the SDOH Core 5 screening tool into the new and improved system and scripts.

COA Region 5: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- COA Region 5 reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

COA Region 5: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. COA Region 5 addressed all validation criteria and received validation ratings of High Confidence for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and COA Region 5 received *High Confidence* for the final Module 4 submission. COA Region 5's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-76 shows the performance measure results for COA Region 5 for MY 2021 through MY 2023.

Table 4-76—Performance Measure Results for COA Region 5

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	36.65%	49.35%	50.58%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	56.03%	49.38%	47.03%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	35.32%	30.19%	29.46%	40.14%
Follow-Up After a Positive Depression Screen	39.21%	49.02%	49.28%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	28.57%	28.93%	25.58%	36.42%

COA Region 5: Strengths

The following performance measure rates for MY 2023 increased from the previous year for COA Region 5:

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

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

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

- *Engagement in Outpatient SUD Treatment* 
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* 
- *Follow-Up Within 7 Days of an ED Visit for SUD* 
- *Follow-Up After a Positive Depression Screen* 

- *Behavioral Health Screening or Assessment for Children in the Foster Care System* 

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[30]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended COA Region 5:

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

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

Based on the recommendations provided by HSAG, COA Region 5 reported implementing the following:

- Ongoing work within its BH program that is designed to identify and intervene with members using bed-based BH services, including inpatient and residential, to prevent readmission. Care managers coordinate care with providers, connect members with appropriate outpatient BH services, and mitigate barriers to discharge or engagement in follow-up services.
- New steering councils and committees have been formed to recommend strategies to improve performance metrics and support workgroups for enhancing population health outcomes by prioritizing measures for high-impact areas of improvement and increased collaboration among providers to share best practices and scale interventions across the network.

HSAG recognizes that the BH care coordination program and new steering committees are likely to help improve and maintain performance rates.

[30] Mao W, Shalaby R, Agyapong VIO. Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. *Healthcare*. 2023; 11(8):1161. Available at: https://www.mdpi.com/2227-9032/11/8/1161. Accessed on: Nov 21, 2024.

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 5 Overall Evaluation

Table 4-77 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-77—Summary of COA Region 5 Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	17	1	0	0	94%~
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%v
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**49**	**5**	**0**	**0**	**91%**

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

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

~ *Indicates no change from review three years prior.*

COA Region 5: Trended Performance for Compliance With Regulations

Table 4-78 presents, for all standards, the overall percentage of compliance score for COA Region 5 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-78—Compliance With Regulations—Trended Performance for COA Region 5

Standard and Applicable Review Years	COA Region 5 Average—Previous Review	COA Region 5 Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	80%	88%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	100%	100%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	91%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**94%**	**94%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	83%	97%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**100%**	**94%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**100%**	**25%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	88%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, COA Region 5 demonstrated consistently high-achieving scores for three standards, one of which maintained 100 percent compliance from the previous review cycle, and the other maintained 94 percent compliance, indicating a strong understanding of most federal and State regulations. Scores for both Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation declined from the previous review cycle with the most notable decrease of 75 percentage points for Standard IX—Subcontractual Relationships and Delegation.

COA Region 5: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 maintained policies pertaining to effective communication, accessibility, and cultural sensitivity that outlined the steps COA Region 5 takes to ensure effective communication with members, including testing readability, keeping the message simple, and understanding the audience.
- COA Region 5 established a clear reporting structure from the Core Policy team and Provider Performance Committee up through the Executive Compliance Committee to the FACC, and ultimately to the Board of Directors.
- Within its QAPI Program Description and Annual Quality Report, COA Region 5 described a comprehensive program that included processes to address the appropriateness of care, quality of care, and member experience. The quality and appropriateness of care for members with SHCN were addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.
- COA Region 5 reviewed CPGs annually and included a process for soliciting feedback from contracted providers. The CPGs were adopted and disseminated to providers and members.

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

HSAG found the following opportunities for improvement:

- Within its electronic provider directory, COA Region 5 did not include the provider website URLs, as required.
- Policies and procedures did not state that COA Region 5 would not knowingly employ any staff members who are "debarred" or "suspended" from participation in federal programs.
- Staff members were unaware of the status of active delegation agreements and were unable to communicate a current process that addressed poor subcontractor performance.
- One delegation agreement did not include the delegated activities or obligations and related reporting responsibilities.
- Some written delegation agreements did not include all of the required language.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Update its provider directory to include the provider URLs.
- Revise its policies and procedures to align in full detail with the federal and State requirements.
- Maintain ultimate responsibility of subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
- Ensure that all delegation agreements specify the delegated activities or obligations and related reporting responsibilities.
- Revise or amend the written delegation agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended COA Region 5:

- Update its procedures to further delineate provider administrative clean claims which are separate from member-related issues in which a service is denied or partially denied. Additionally, enhance policies, procedures, and monitoring to ensure that the member is notified in writing of the denial or partial denial of a service.
- Enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.
- Improve its NABD template and monitoring procedures to ensure clinical language, including abbreviations, are clearly defined and explained in plain language (e.g., partial hospitalization program [PHP], a part-time treatment for addiction where members do not live on-site but may visit several times a week).
- Remove the inaccurate statement in its Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, COA Region 5 reported updating policies, procedures, and monitoring to ensure that the member is notified in writing of the denial or partial denial of a service and decisions are made within the required time frame. In addition, COA Region 5 enhanced its NABD template and monitoring procedures to ensure clinical language and abbreviations were clearly defined within the letter. Inaccurate language in the policy was also revised that directed the member to follow up an oral appeal request in writing. HSAG recognizes that updating policies procedures, and enhancing monitoring, is likely to result in long-term improvements.

Validation of Network Adequacy

COA Region 5: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 demonstrated strength in the PH primary care network category, meeting all minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Family Practitioner (MD, DO, NP, CNS, and PA).
- COA Region 5 demonstrated strength in the BH network category, meeting all minimum network requirements for both General and Pediatric Behavioral Health, both General and Pediatric Psychiatrists and other Psychiatric Prescribers, both General and Pediatric SUD Treatment Practitioner, and Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals.
- COA Region 5 met all minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.1, 3.5, and 3.7 WM in the contracted county.
- COA Region 5 improved upon its provider specialty matching since converting to the use of HRP, as it now relies solely upon the use of taxonomy codes for specialty matching instead of its previous process that included the use of multiple values (i.e., specialty description and provider types) to identify provider specialty.
- COA Region 5 maintains detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.

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

HSAG found the following opportunities for improvement:

- COA Region 5 did not meet the minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.2 WM, 3.3 and 3.7 WM in the contracted county.
- COA Region 5 indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when COA Region 5 is informed of a change in member demographic information.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Conduct an in-depth review of provider categories for which COA Region 5 did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract

standards was the result of a lack of providers or an inability to contract providers in the geographic area.

- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that COA Region 5 continue to conduct an in-depth review of provider categories for which COA Region 5 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that COA Region 5:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, COA Region 5 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure COA Region 5's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 NAV Recommendations

In response to HSAG's recommendation, COA Region 5 reported taking the following actions:

- Reported that the inability to meet indicated time and distance standards is due to the taxonomy codes for SUD treatment facilities (particularly ASAM LOC 3.1 and above) not tracking to the correct category. COA Region 5 stated it obtains taxonomy code information from the Department MCO report based on how providers fill out their information for the Department's provider validation. However, these taxonomy codes do not always align with a provider's NPI provider type and may not be validated at the location level.

- Updated the provider directory with data refreshed every evening. COA Region 5 reported that within its directory a form is available that anyone, including members, may use to report incorrect data or issues accessing providers listed in the directory.
- Described that all credentialed providers are listed in COA Region 5's provider directory with information related to provider specializations, location, clinic office hours, status of accepting new members, cultural competency, race/ethnicity, gender, pronouns, ADA accessibility, and languages spoken. The provider directory also lists all BH subspecialties and ASAM LOCs, increasing the ability to identify and connect members to the appropriate level of specialized care.
- Reported that credentialing and provider data maintenance teams at COA Region 5 entered provider data into COA Region 5's credentialing database using several different sources including information provided through the provider application and required appendix, as well as CAQH summaries.

Based on the above response, COA Region 5 worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-79 presents COA Region 5's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-79—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for COA Region 5

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	84.7%	100.0%
Diagnosis Code	89.8%	90.5%	97.1%
Place of Service	NA	63.5%	99.3%
Service Category Modifier	NA	85.4%	100.0%
Units	NA	96.4%	99.3%
Revenue Code	92.0%	NA	NA
Discharge Status	90.5%	NA	NA
Service Start Date	92.0%	96.4%	100.0%
Service End Date	34.3%	96.4%	100.0%
Population	NA	96.4%	100.0%

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Duration	NA	92.0%	99.3%
Staff Requirement	NA	84.7%	97.1%

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

Table 4-80 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with COA Region 5's EDV results for each of the validated data elements.

Table 4-80—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for COA Region 5

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

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

COA Region 5: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 self-reported high overall accuracy with 90 percent accuracy or above for three of the five inpatient services data elements, six of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that COA Region 5's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with all five inpatient services data elements, seven of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in COA Region 5's EDV results, COA Region 5's self-reported EDV results for inpatient services and psychotherapy services demonstrated a moderate level of encounter data accuracy, with a 34.3 percent accuracy rate for the *Service End Date* inpatient services data element and a 63.5 percent accuracy rate for the *Place of Service* psychotherapy services data element when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends COA Region 5:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended COA Region 5 consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

COA Region 5 reported implementing CAPs for providers with a sufficient number of records that scored below a 95 percent in the RAE 411 over-read. The CAPs included a root-cause analysis, retraining staff, enhancing systems, and provider re-audits. COA Region 5 also reported offering provider education and training on quality documentation.

Based on COA Region 5's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

COA Region 5: Adult CAHPS

Table 4-81 shows the adult CAHPS results for COA Region 5 for FY 2021–2022 through FY 2023–2024.

Table 4-81—Adult CAHPS Results for COA Region 5

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	57.97%	56.04%	56.36%
Rating of All Health Care	52.17%+	50.00%	52.78%
Rating of Personal Doctor	76.36%	64.62%	62.41%
Rating of Specialist Seen Most Often	70.00%+	72.29%+	67.50%+
Getting Needed Care	78.33%+	78.92%	78.46%+
Getting Care Quickly	78.03%+	81.76%+	77.84%+
How Well Doctors Communicate	93.52%+	93.66%	93.71%+
Customer Service	85.56%+	87.42%+	84.43%+
Coordination of Care	82.35%+	90.41%+	77.78%+ ▼
Advising Smokers and Tobacco Users to Quit	75.00%+	67.53%+	63.33%+
Discussing Cessation Medications	61.29%+	50.00%+	42.86%+
Discussing Cessation Strategies	56.67%+	53.33%+	51.09%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

COA Region 5: Strengths

The following measures' FY 2023–2024 scores for COA Region 5 were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Discussing Cessation Strategies*

The following measures' FY 2023–2024 scores for COA Region 5 were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*

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

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

The following measures' FY 2023–2024 scores for COA Region 5 were lower, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Coordination of Care*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*

The following measure's FY 2023–2024 score for COA Region 5 was statistically significantly lower than the FY 2022–2023 score:

- *Coordination of Care*

To address these low CAHPS scores, HSAG recommends COA Region 5 consider:

- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on members' experiences, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers.
- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

- Obtaining and analyzing members' experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset patient, providing solutions, or making amends for problems that the patient reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Providing internal training sessions and sending out newsletters designed to educate providers on the importance of guiding and advising smokers and tobacco users to quit. The training could emphasize the importance of doctors speaking directly to their members about quitting. It can provide information and advice on speaking to members about potential long-term health implications related to tobacco use, strategies for tobacco cessation, and educating the patients on long-term health outcomes if they continue tobacco use versus tobacco cessation.

COA Region 5: General Child CAHPS

Table 4-82 shows the general child CAHPS results for COA Region 5 for FY 2021–2022 through FY 2023–2024.

Table 4-82—General Child CAHPS Results for COA Region 5

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	77.34%	75.09%	76.41% ↑
Rating of All Health Care	74.05%	70.56%	72.25%
Rating of Personal Doctor	84.95%	83.47%	80.09%
Rating of Specialist Seen Most Often	77.78%+	85.94%+	75.47%+
Getting Needed Care	81.03%	81.15%	83.51%
Getting Care Quickly	84.24%+	80.91%	84.71%
How Well Doctors Communicate	92.56%	96.44%	94.13%
Customer Service	88.84%+	89.08%+	87.80%+
Coordination of Care	89.47%+	87.18%+	83.95%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

COA Region 5: Strengths

The following measure's FY 2023–2024 score for COA Region 5 was statistically significantly higher than the 2023 NCQA national average:

- *Rating of Health Plan*

The following measures' FY 2023–2024 scores for COA Region 5 were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measure's FY 2023–2024 score for COA Region 5 was lower, although not statistically significantly, than the 2023 NCQA national average:

- *Getting Care Quickly*

The following measures' FY 2023–2024 scores for COA Region 5 were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*

To address these low CAHPS scores, HSAG recommends COA Region 5 consider:

- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child

members perspectives. Physicians could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers.

- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker of the child member, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, COA Region 5 reported engaging in the following QI initiatives:

- In addition to CAHPS results, supplemental feedback was gathered through member satisfaction surveys, developed with input from members and member-facing teams. Those surveys provided actionable insights and were guided by the Member Advisory Council, internal teams, and population health data. In spring 2023, questions on racial, cultural, and ethnic identities, as well as general member experience questions, were included in the survey. By spring 2024, COA continued with recurring questions on improvement to the member experience and added questions on health-related social needs and member communication preferences. COA is developing a new initiative to create a community feedback loop. This project will be aimed at assessing the current state of how COA seeks member feedback, pilot an improved member feedback loop model, and explore incentive models for member and community participation.
- With its commitment to understanding and addressing disparities within its population that may contribute to lower performance among specified race or ethnicity groups, age groups, ZIP Codes, and other demographics, COA conducted an internal satisfaction survey, which was designed to collect comprehensive information on member demographics. This allowed COA to analyze

qualitative responses such as access to care issues and timeliness of services in conjunction with demographic data.

- A CAHPS communication plan was developed and implemented. The plan included detailed information on the CAHPS survey, covering its purpose; data collection timeline; and its benefits to members, providers, and the Health First Colorado system. This information, along with links to CAHPS results, were communicated through various channels such as the provider manual, the monthly provider updates, the internal COA employee newsletter, the member newsletter, and COA's social medical platforms. Provider-facing teams were available to address any provider questions regarding the CAHPS survey and reported any barriers encountered to internal staff members.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 CAHPS Recommendations

HSAG has determined that COA Region 5 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with COA Region 5.

QUIP

Table 4-83 presents COA Region 5's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-83—Summary of COA Region 5 QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Discharge Status	89.8%	100%	100%	100%
Psychotherapy Services	Procedure Code	88%	100%	33%	100%
	Place of Service	77%	67%	67%	67%
	Service Category Modifier	88%	100%	33%	NA

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

COA Region 5: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 surpassed 90 percent accuracy for two out of four data elements across two service categories included in the QUIP.

- Key interventions for the QUIP consisted of a CAP, additional training, and education on the topic of technical documentation requirements for valid provider signatures and place of service.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- COA Region 5 reported low results for the psychotherapy services *Place of Service* data element due to service documentation not matching the place of service listed on the billed claim.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that COA Region 5 maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 QUIP Recommendations

COA Region 5 reported that it implements CAPs for providers that score below 95 percent encounter accuracy in the 411 EDV and requests enough records to assess general documentation practices. COA Region 5 has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that the implementation of CAPs for providers that score below 95 percent encounter accuracy is likely to improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-84 displays the MHP Audit compliance scores for COA Region 5 for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-84—FY 2023–2024 MHP Audit Score for COA Region 5

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
COA	5	94%	Inpatient	93%	95%^
			Outpatient	98%	

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

COA Region 5: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5 demonstrated an overall score of 95 percent.
- COA Region 5 used InterQual UR criteria for all MH determinations and ASAM LOC criteria for all SUD determinations.
- COA Region 5 required its UM staff members to pass IRR testing annually with a minimum score of 90 percent or better.
- All files demonstrated that COA Region 5 followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services.
- COA Region 5 utilized *The ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice.
- COA Region 5 made the denial determinations and providers were notified of the denial determinations within the required time frame for most records reviewed. Providers were notified by telephone, secure email, and/or a copy of the NABD.
- COA Region 5 used an extension in two records reviewed to obtain additional information, and the extension letters were sent to the member within the required time frame and included the required content.

- In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except two, the records contained evidence that a peer-to-peer review was offered to the requesting provider.
- Within two records that were denied due to lack of adequate documentation to determine medical necessity, both records demonstrated that COA Region 5 reached out to the requesting provider for additional information.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system.
- All NABDs included the required content, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA Region 5 in filing an appeal, access to pertinent records, and a brief reason for the denial.
- COA Region 5 staff members described updates to COA Region 5's UM software system, which included enhanced oversight capabilities, allowing for additional monitoring of how UM staff members interact and follow up with care management. Furthermore, when communicating with providers regarding UM changes or updates, COA Region 5 described organizational efforts to communicate with providers through the provider-facing website, newsletters, and direct fax blasts.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- In some cases, COA Region 5 did not notify the provider of the denial determination or send the NABD to the member within the required time frame.
- Two records reviewed did not contain evidence that a peer-to-peer review was offered to the requesting provider.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Enhance monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame. Additionally, ensure that staff members are documenting the method of communication to the requesting provider in the UM system.
- Follow established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- As a best practice, include in the NABDs (other than the SUD NABDs, which included the required ASAM dimensions) reference to COA Region 5's criteria (i.e., InterQual) used in making the

determination and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 5 found to be present or not present related to the criteria).

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended COA Region 5:

- Ensure all denial determinations due to medical necessity use established UR criteria (InterQual or ASAM).
- Enhance monitoring procedures to ensure that the provider is made aware of the denial determination within the required time frame and the member is sent the NABD within the required time frame.
- Conduct periodic staff training and monthly record audits to ensure NABDs are sent at an easy-to-understand reading grade level for the member.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA Region 5 found to be present or not present, related to the criteria).

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 MHP Recommendations

COA Region 5 reported addressing HSAG's recommendations by:

- Providing ongoing training for COA Region 5 staff members to ensure staff members are proficient in applying InterQual and ASAM criteria consistently. Additionally, COA Region 5 reported reviewing regular audit metrics and procedures to confirm accurate analysis of team performance as it relates to denial determinations.
- Reviewing and optimizing COA Region 5 internal processes to ensure timely communication of denial determinations and emphasizing the importance of adhering to time frames to ensure compliance during staff trainings.
- Conducting staff training and record audits for COA Region 5 UM staff members.
- Including more specific information regarding the member's condition that are meant to convey the criteria and reason for the denial determination and evaluating the NABD templates for improvement.

COA Region 5 still has the opportunity to address HSAG's recommendation of enhancing monitoring procedures to ensure that the provider is notified of the denial determination and the member is sent the NABD within the required time frame, and include the specific name of the criteria (i.e., InterQual) used to make the denial determination and include more member-specific information within the NABD. HSAG acknowledges that COA Region 5 pursued additional guidance from HSAG and the Department regarding NABD template updates to include InterQual language in a manner that is member friendly.

COA Region 5's reported updates will most likely demonstrate improvement to overall UM processes. COA Region 5 should continue to address the recommendations made by HSAG to achieve MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, COA Region 5 investigated 51 potential QOCG cases. COA Region 5's average membership in CY 2023 was 159,263, with 138,041 members enrolled as of December 31, 2023. Of the 10 QOCG cases submitted by COA Region 5, five cases were substantiated.

COA Region 5: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- COA Region 5's documentation submission included a QOC training video and emails as evidence as to how COA Region 5 informs staff members about the importance of identifying and reporting QOCs.
- Staff members shared that COA Region 5 moved to a more proactive approach to address potential grievances, coming from a place of education, before issues are escalated to a CAP. Due to the proactive approach, COA Region 5 staff members described a new process to meet with the provider/facility to address issues and provide education before initiating a CAP. COA Region 5 did not require a CAP for any of the 10 sample cases reviewed.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- The policies and procedures noted a goal of closing 90 percent of QOCG cases within 90 days but did not indicate a time frame for acknowledging receipt of QOCGs. During the interview, COA Region 5 staff members shared that their internal goal is to acknowledge each QOCG within 24 business hours of receipt. HSAG could not determine if all cases were acknowledged within 24 business hours and closed in less than 90 days because one of the cases did not include the dates for the acknowledgement and resolution letter, and a second case did not have a date on the acknowledgement letter. COA Region 5 staff members explained that the encrypted emails expired and could not be retrieved. Eight of 10 cases reviewed included documentation that cases were acknowledged within 24 business hours, and nine of the cases reviewed included documentation that cases were closed in less than 90 days.
- Three of the 10 sample cases reviewed were originally initiated by the member or the member's family; however, there was no documentation that the members received acknowledgment or resolution. During the interview, COA Region 5 confirmed that the QM department considers the

staff member who submits the case to the QOC inbox as the originator of the concern and provides the acknowledgement and resolution letter to that staff member via email.

- COA Region 5's *Quality of Care Concerns* policy stated that the QM department may follow up with the member to determine if the member's immediate healthcare needs are being met. During the interview, COA Region 5 staff members indicated that if the case originates as a grievance, a care coordinator and/or grievance staff member may follow up with the member in real time. However, staff members stated that the QM department does not have any direct contact with the member. Although the QM department can see care coordination notes in the care management system, COA Region 5 did not have a policy or describe procedures for ensuring that appropriate member follow-up occurs. When submitting follow-up documents after the interview, COA Region 5 provided verification of member follow-up through care coordination system notes.
- COA Region 5's website includes information about how to file a grievance, an online submission form for submitting a grievance, and what the member can expect after filing a grievance. However, the website did not distinguish between a member grievance and a QOCG.
- The policies and procedures described case-specific reporting to the Department when the case is submitted to COA Region 5 by Department staff members; however, COA Region 5 did not submit or describe policies or procedures to inform the Department of receipt of a QOC or to submit a QOC summary as detailed in the MCE contract.

To address these opportunities, HSAG recommends that COA Region 5:

- Further define within the applicable policies and procedures its internal timeliness goals for acknowledging and investigating QOCGs.
- Establish clear follow-up processes to ensure that member follow-up is occurring to determine whether the member's healthcare needs are being met, regardless of where the QOCG originates.
- Define the thresholds for trending facilities to provide guidance and accountability related to implementation of CAPs.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Implement a process for notifying the Department that a QOCG has been received and expand its QOC summary process to include all QOCGs received, rather than just those referred by the Department.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023.

EPSDT Audit

Table 4-85 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-85—FY 2023–2024 EPSDT Audit Findings for COA Region 5

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	38%	69%
Post-Denial Record Review	92%	58%	75%

COA Region 5: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- All five cases denied due to the member being in DHS custody received care coordination services that assisted in connecting members with the requested services not covered by COA Region 5. Several of those cases included ongoing care coordination meetings involving both COA Region 5 and the Department to ensure the member receives the appropriate services through EPSDT.
- Multiple COA Region 5 policies outlined effective mechanisms to track referrals and warm handoffs, and care coordination services included connecting members, DHS, providers, and the Department to ensure members receive appropriate care.
- Fourteen of the 15 non-utilizer sample members received at least one outreach attempt during the review period.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- Within the records reviewed, there was no explicit documentation of how the EPSDT definition of "medical necessity" was implemented.
- One COA Region 5 newsletter demonstrated that although EPSDT information was mentioned, the information was unclear and required revisions in the following months.

- Medical necessity denials reviewed demonstrated that COA Region 5 UM staff members utilized InterQual criteria, which do not explicitly consider EPSDT within the review process. Additionally, none of the medical necessity denials reviewed included specific documentation of the EPSDT definition of "medical necessity."
- One of the denial records reviewed included a denial for psychological testing due to a noncovered diagnosis. However, the prior authorization request listed only covered mental health diagnoses as provisional diagnoses, and during the interview, COA Region 5 staff members stated that the request may have been incorrectly categorized as a request for a noncovered diagnosis.
- COA Region 5's NABD template mostly followed the Department's template; however, COA Region 5 did not complete the section related to the clinical criteria utilized when making the determination.
- Four denial cases reviewed did not have any documentation of referral to or denial of care coordination services. The applicable members would have benefited from assistance with care coordination services.
- COA Region 5's well-visit flyer included information regarding well visits and immunizations and that these services are free of charge, but the flyer did not specifically state EPSDT language or the other available services the member is eligible for through the EPSDT benefit.
- Five members within the non-utilizer sample did not receive a successful IVR outreach, and COA Region 5 conducted additional outreach to these members using the same IVR outreach modality. However, the additional outreach attempts were a mix of successful and unsuccessful for the five members.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Strengthen its UM procedures to ensure the full EPSDT definition of "medical necessity" is considered during the review process.
- Strengthen its internal review procedures with clinical leadership and subject matter experts prior to distributing provider manuals.
- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to InterQual or ASAM, prior to issuing a denial.
- Continue to provide training and monitoring related to denial of services due to a noncovered diagnosis to ensure UM staff members review all available documentation and members receive all appropriate services available to them.
- Update its NABDs to include UM criteria utilized to be in compliance with the CFR, CCR, and the Department's NABD template.

- Provide ongoing training and audits to ensure staff members are following policies and procedures in place to ensure members are receiving care coordination referrals when appropriate.
- Work with the Department to update the well-visit flyer to include additional EPSDT information.
- Consider sending a mailed letter to the member when additional IVR outreach is not successful/completed due to system errors.

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended COA Region 5:

- Ensure its CM staff members proactively offer assistance with scheduling appointments and transportation if the need is relevant to the member's situation. Furthermore, COA Region 5 may consider the addition of an EPSDT information flyer in applicable NABD mailings to enhance member/family awareness of available services. Additionally, HSAG suggests the addition of member-specific assistance, next steps, and offering transportation when applicable to the member's situation.
- Add additional outreach in the form of a phone call to the requesting provider before or after the issuance of the notice of denial.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 EPSDT Recommendations

COA Region 5 reported addressing HSAG's recommendations by:

- Providing training to care management staff members on EPSDT from a partner organization, Family Voices, which included information on transportation benefits. Additionally, COA Region 5 plans on continuing annual training to staff members regarding EPSDT.
- Keeping strong communication channels between the provider network and UM staff members and enhancing notification of the NABD, as needed.

COA Region 5 still has the opportunity to consider the addition of adding an EPSDT informational flyer in applicable NABD mailings to enhance awareness of available services and adding member-specific information, assistance available, next steps, and offering transportation. COA Region 5's reported updates will likely demonstrate improvement to UM processes; however, COA Region 5 should continue to address the recommendations by HSAG to improve member communication, awareness, and ensure EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-86 presents the number of cases in the sample that HSAG reviewed for COA Region 5 and the percentage of cases in which HSAG's reviewers agreed with COA Region 5's denial determination.

Table 4-86—COA Region 5 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
COA Region 5	25	20[1]	20	100%

[1] *Five samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 20.*

COA Region 5: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for COA Region 5:

- HSAG's reviewers agreed with the denial determinations in 100 percent of the sample cases.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- COA Region 5 did not document notification to the provider regarding the denial determination when the denial was due to an administrative decision (e.g., late notification by the requesting provider).
- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations.

To address these opportunities for improvement, HSAG recommends COA Region 5:

- Enhance monitoring mechanisms to ensure adherence to the required time frame for notifying the provider and member of the denial determination.
- Provide training for providers and UM reviewers on the importance of considering the member's interdimensional interactions and co-occurring problems in the review process.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that COA Region 5:

- Develop and use an NABD template to ensure that member communications regarding adverse benefit determinations include the full meaning of an acronym the first time it is used (e.g., substance use disorder [SUD], intensive outpatient [IOP], and American Society of Addiction Medicine [ASAM]) and to ensure letters contain all required content.

Assessment of COA Region 5's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

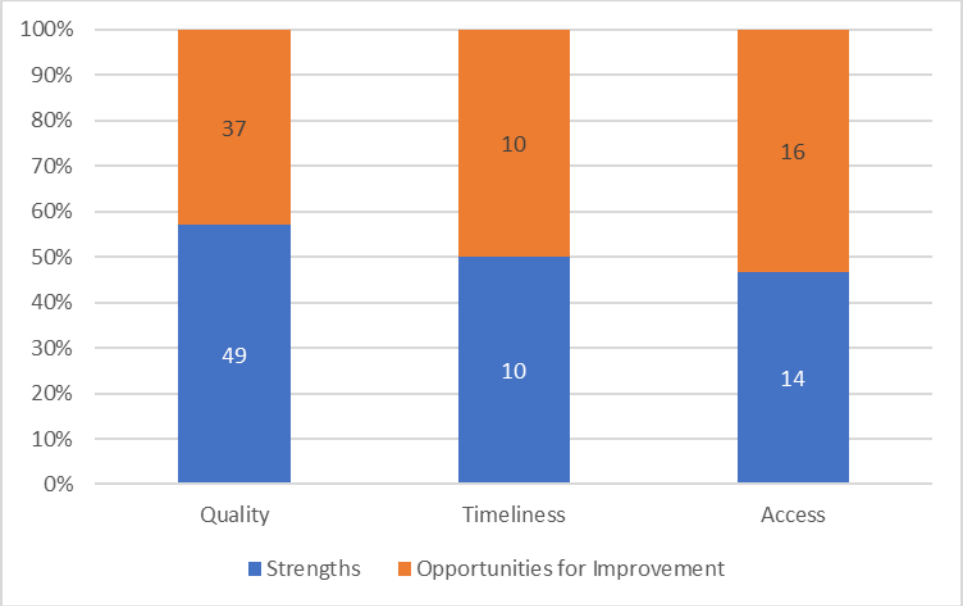
COA Region 5 reported addressing HSAG's recommendations by:

- Ensuring COA UM auditing procedures include evaluating NABDs for acronym usage and continuing to direct staff to write out the full meaning for each instance.

COA Region 5 should continue to address the recommendations made by HSAG in an effort to improve the communication with its members regarding denial determinations.

Region 6—Colorado Community Health Alliance

Figure 4-6—Number of Strengths and Opportunities for Improvement by Care Domain for CCHA Region 6*



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

The following are CCHA Region 6's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment related to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

CCHA Region 6 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP and the nonclinical *Social Determinants of Health (SDOH) Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. CCHA Region 6 resubmitted both PIPs and received an overall *High Confidence* level for the final validation. Table 4-87 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUH*

Table 4-87—2023–2024 PIP Overall Confidence Levels for the *FUH* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	88%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUH* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. CCHA Region 6 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-88—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. CCHA Region 6 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUH*

Table 4-89 displays data for CCHA Region 6's *FUH* PIP.

Table 4-89—Performance Indicator Results for the *FUH* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 751 D: 1,500	50.07%					

N–Numerator D–Denominator

For the baseline measurement period, CCHA Region 6 reported that the percentage of discharges of CCHA Region 6 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 was 50.07 percent.

Nonclinical PIP: *SDOH Screening*

Table 4-90 displays data for CCHA Region 6's *SDOH Screening* PIP.

Table 4-90—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 708 D: 2,227	31.79%					

N–Numerator D–Denominator

For the baseline measurement period, CCHA Region 6 reported that 31.79 percent of members attributed to Region 6 with new Behavioral Health Transitions of Care (BHTOCs) and Specialized Transitions of Care (STOCs) cases were screened for unmet food, housing, utility, and transportation needs.

Interventions

Clinical PIP: *FUH*

Table 4-91 displays the barriers and interventions documented by the health plan for the *FUH* PIP.

Table 4-91—Barriers and Interventions for the *FUH* PIP

Barriers	Interventions
• Manual verification of the member's treatment status with mental health provider at the time of hospitalization can lead to attribution errors. • Lack of a standardized process to verify and/or obtain up-to-date contact information for all members for effective outreach and engagement efforts. • Manual tracking of coordination efforts and lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement. • No process to reconcile inconsistencies between manual tracking and claims data.	Improve process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.

Nonclinical PIP: *SDOH Screening*

Table 4-92 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-92—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and Acute Treatment Unit (ATU) for a BH condition, or high levels of care for a SUD event.	Standardize requirements for screening CCHA members enrolled in BHTOC and STOC programming for unmet food, housing, utility, and transportation needs.

CCHA Region 6: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.

- CCHA Region 6 reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

CCHA Region 6: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. CCHA Region 6 addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and CCHA Region 6 received *High Confidence* for the final Module 4 submission. CCHA Region 6's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-93 shows the performance measure results for CCHA Region 6 for MY 2021 through MY 2023.

Table 4-93—Performance Measure Results for CCHA Region 6

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	41.61%	45.37%	51.62%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	64.51%	58.07%	60.81%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	35.30%	31.99%	34.15%	40.14%
Follow-Up After a Positive Depression Screen	47.48%	52.98%	55.74%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	17.82%	18.09%	13.25%	36.42%

CCHA Region 6: Strengths

The following performance measure rates for MY 2023 increased from the previous year for CCHA Region 6:

- *Engagement in Outpatient SUD Treatment*

- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* 
- *Follow-Up Within 7 Days of an ED Visit for SUD* 
- *Follow-Up After a Positive Depression Screen* 

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

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

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

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[31]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 6:

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

[31] Ibid.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

Based on the recommendations provided by HSAG, CCHA Region 6 reported implementing the following:

- Detailed review of all provided performance data to promote accuracy and congruence with internally calculated projections. Providers are routinely notified of pertinent measure rates to gauge performance and intervention opportunities.
- A partnership with the CMHCs on PIPs to define and enhance clinical pathways to support clients' transition from inpatient placements. CCHA care coordinators as well as CMHC staff members work with members and facilities to establish timely BH follow-up services post-discharge.

HSAG recognizes that the CCHA's focus on monitoring performance data and data sharing, as well as its partnerships and support to providers, are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 6 Overall Evaluation

Table 4-94 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-94—Summary of CCHA Region 6 Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%~
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**53**	**1**	**0**	**0**	**98%**

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

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

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

~ *Indicates no change from review three years prior.*

CCHA Region 6: Trended Performance for Compliance With Regulations

Table 4-95 presents, for all standards, the overall percentage of compliance score for CCHA Region 6 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-95—Compliance With Regulations—Trended Performance for CCHA Region 6

Standard and Applicable Review Years	CCHA Region 6 Average—Previous Review	CCHA Region 6 Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	83%	94%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	94%	100%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	100%	90%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**87%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	71%	74%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**100%**	**100%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**100%**	**75%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	75%	86%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, CCHA Region 6 demonstrated consistently high-achieving scores for three out of four standards, of which two standards maintained a score of 100 percent following the previous review cycle. Most notably, Standard V—Member Information Requirements increased by 13 percentage points, demonstrating a strong understanding of most federal and State regulations.

CCHA Region 6: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CPGs were reviewed and discussed during the advisory committee before they were adopted and made available to both providers and members on the website.

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

HSAG found the following opportunities for improvement:

- Some written agreements did not include all of the required language.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Revise or amend the written agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 6:

- Update its BH provider manual, peer-to-peer desktop process, UM workflow, UM program description, UM review desktop procedure, letter desktop procedure, and any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD.
- Revise its NABD templates and letter writing procedure for SUD requests to include information about all dimensions and enhance its oversight and monitoring to ensure accurate letters for members.
- Enhance its messaging to members in a way that encourages members to express grievances freely without the barrier of a perceived second "formal" step. Additionally, update and conduct a refresher training that reiterates the enhanced messaging to members who are expressing dissatisfaction.
- Develop a refresher training about how to handle additional information received by the member and monitor staff member documentation to ensure that representatives are taking down additional information from any member who calls to give more information on an open case.
- Modify documentation located on the CCHA Region 6 website to accurately state that a grievance acknowledgement letter will be sent to the member within two working days.
- Update documentation located on the CCHA Region 6 website to remove the statement that a verbal appeal must be followed up with a written appeal and update its appeal acknowledgement letters to remove any requirement that the member must follow up with a verbal appeal in writing.

- Ensure that all appeal acknowledgement letters accurately identify the correct time frame for the resolution of an appeal.
- Update the member appeals policy to include that a member may file a grievance if they disagree with the appeal decision.
- Enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of a member, an extension letter is sent to the member, and they are given prompt oral notice of the delay.
- Update the appeal resolution letter to include the RAE's contact phone number and remove "written" from the appeal resolution letter with regard to continuation of benefits.
- Update its BH provider manual to remove inaccurate language such as appeal information under the grievance section and requiring the member to attach documentation, as well as add language that the MCE will make reasonable effort to provide oral notice of resolution in the case of an expedited appeal.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, CCHA Region 6 updated the BH provider manual, NABD templates, desktop procedures, UM workflows, UM program descriptions, appeal policies, appeal resolution letters, and other policies and procedures to come into compliance with the recommendations. In addition, CCHA Region 6 updated and conducted a refresher training that reiterated the enhanced messaging to members who express dissatisfaction. CCHA Region 6 enhanced policies, procedures, and training for staff members to ensure that for members who request an extension, or an extension is needed in the best interest of the member, an extension letter is sent to the member, and members are given prompt oral notice of the delay. HSAG recognizes that updating multiple documents including provider manuals, templates, and policies and procedures, is likely to result in long-term improvements.

Validation of Network Adequacy

CCHA Region 6: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 performed strongly in the BH network category, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties. Additionally, while CCHA Region 6 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 20 percent and 40 percent of contracted counties, respectively, the rate of access for these provider types was 99 percent or greater in all contracted counties.
- While CCHA Region 6 did not meet the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) or Family Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties, for each of the three provider types, CCHA Region 6 demonstrated high rates of access, with all counties displaying 99.7 percent or greater access.
- While CCHA Region 6 did not meet the minimum network requirements for SUD Treatment Facilities–ASAM LOCs 3.5 and 3.7 across all contracted counties, the rate of access for these provider types in counties where the plan failed to meet the minimum network requirements ranged from 93.2 percent to greater than 99.9 percent.
- CCHA Region 6 maintained a thoroughly documented deliverable validation process, which included a Responsible, Accountable, Consulted and Informed (RACI) matrix that identified the responsible, accountable, consulted, and informed individuals for each phase of the deliverable. This documented process helped CCHA Region 6 ensure business continuity in its network adequacy reports and its ability to maintain detailed steps to ensure the accuracy of these submissions.

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

HSAG found the following opportunities for improvement:

- CCHA Region 6 did not meet the minimum network requirement for SUD Treatment Facilities–ASAM LOCs 3.1, 3.2 WM, 3.3, 3.5, and 3.7 WM in all contracted counties.
- CCHA Region 6 did not meet the minimum network requirement for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties. In 60 percent of the contracted counties, access for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals ranged from 98.9 percent to greater than 99.9 percent, and in the remaining 40 percent of counties, access ranged from 4.1 percent to 35.1 percent.

- CCHA Region 6 indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when CCHA Region 6 is informed of a change in member demographic information.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Conduct an in-depth review of provider categories for which CCHA Region 6 did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that CCHA Region 6 continue to conduct an in-depth review of provider categories for which CCHA Region 6 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that CCHA Region 6:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, CCHA Region 6 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the CCHA Region 6 data that could not be located in the online provider directory.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 NAV Recommendations

In response to HSAG's recommendation, CCHA Region 6 reported taking the following actions:

- Added ASAM facilities to the CCHA BH network to further improve compliance.

- At minimum, network adequacy validation reports and annual plans were reviewed by provider relations staff/network managers and leadership for oversight, monitoring, and feedback quarterly.
- Communicated expectations to BH providers regarding hours of operation. The CCHA Behavioral Health Provider Manual requires providers to post a statement in their offices detailing hours of operation. Provider office hours can vary due to the nature of BH services. CCHA verified directories and hours of operation were correct as indicated by providers.
- Reviewed the survey responses current as of the time of the audit to identify opportunities for improvement. The findings indicated two large provider groups with multiple office locations had staff who declined to participate during the survey, which was tracked as a noncompliant response. Both providers were outreached directly to discuss the survey and participation.

Based on the above response, CCHA Region 6 worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-96 presents CCHA Region 6's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-96—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 6

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	91.2%	95.6%
Diagnosis Code	94.2%	89.1%	90.5%
Place of Service	NA	76.6%	94.2%
Service Category Modifier	NA	91.2%	92.7%
Units	NA	97.1%	92.7%
Revenue Code	91.2%	NA	NA
Discharge Status	97.8%	NA	NA
Service Start Date	97.8%	98.5%	94.9%
Service End Date	95.6%	98.5%	94.9%
Population	NA	98.5%	96.4%
Duration	NA	96.4%	95.6%
Staff Requirement	NA	94.2%	96.4%

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

Table 4-97 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with CCHA Region 6's EDV results for each of the validated data elements.

Table 4-97—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 6

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

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

CCHA Region 6: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 self-reported high overall accuracy with 90 percent accuracy or above for all five inpatient services data elements, eight of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that CCHA Region 6's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with four of the five inpatient services data elements, all 10 psychotherapy services data elements, and nine of the 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in CCHA Region 6's EDV results, CCHA Region 6's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with a 76.6 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 6 consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

CCHA Region 6 reported continuous assessments and enhancements of its multifaceted approach to promote ongoing improvements to the accuracy of encounter data submissions. CCHA Region 6 reported utilizing website postings, sending a monthly News and Updates newsletter to providers, and regularly distributing a Behavioral Health Provider Bulletin. CCHA Region 6 additionally noted hosting a monthly Behavioral Health Provider Open Mic Call that serves as a forum to share updates, respond to providers' questions, and review mock audit exercises. CCHA Region 6 also reported disseminating routine updated guidelines to provide clarity on audit requirements, common mistakes, and provide a self-audit checklist. CCHA Region 6 also noted sharing practice-level scorecards with the providers' results for each audited element to guide necessary corrections. CCHA Region 6 noted referring findings indicative of substantial risk of improper billing to the Special Investigations Unit for further review, monitoring, and determination of required action. Additionally, CCHA Region 6 reported regular review of service claims to identify practices that may benefit from additional assistance. Additionally, CCHA Region 6 noted that Behavioral Health Practice Transformation Coaches work with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements to reduce the number of denied claims. Finally, CCHA Region 6 utilized CAPs to provide structure, clarity of expectations, and accountability for established improvement efforts.

Based on CCHA Region 6's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

CCHA Region 6: Adult CAHPS

Table 4-98 shows the adult CAHPS results for CCHA Region 6 for FY 2021–2022 through FY 2023–2024.

Table 4-98—Adult CAHPS Results for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	56.93%	49.67%	50.36% ↓
Rating of All Health Care	62.77%+	47.66%	52.81%+
Rating of Personal Doctor	68.81%	56.78%	64.71%
Rating of Specialist Seen Most Often	67.14%+	56.58%+	57.38%+
Getting Needed Care	84.81%+	79.11%+	76.25%+
Getting Care Quickly	78.25%+	82.73%+	79.22%+
How Well Doctors Communicate	91.24%+	91.27%+	91.25%+
Customer Service	91.43%+	85.99%+	93.49%+
Coordination of Care	72.22%+	81.25%+	83.67%+
Advising Smokers and Tobacco Users to Quit	57.14%+	63.16%+	69.49%+
Discussing Cessation Medications	40.74%+	41.82%+	43.10%+
Discussing Cessation Strategies	35.71%+	41.82%+	42.11%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

CCHA Region 6: Strengths

The following measure's FY 2023–2024 score for CCHA Region 6 was higher, although not statistically significantly, than the 2023 NCQA national average:

- *Customer Service*

The following measures' FY 2023–2024 scores for CCHA Region 6 were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Customer Service*
- *Coordination of Care*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

The following measure's FY 2023–2024 score for CCHA Region 6 was statistically significantly lower than the 2023 NCQA national average:

- *Rating of Health Plan*

The following measures' FY 2023–2024 scores for CCHA Region 6 were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends CCHA Region 6 consider:

- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Obtaining and analyzing members' experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills

include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers.

CCHA Region 6: General Child CAHPS

Table 4-99 shows the general child CAHPS results for CCHA Region 6 for FY 2021–2022 through FY 2023–2024.

Table 4-99—General Child CAHPS Results for CCHA Region 6

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	68.78%	64.19%	68.54%
Rating of All Health Care	68.85%	68.00%	65.08%
Rating of Personal Doctor	76.47%	76.32%	72.19%
Rating of Specialist Seen Most Often	83.78%+	75.86%+	65.85%+
Getting Needed Care	89.36%+	86.83%	82.34%+
Getting Care Quickly	85.37%+	87.54%	88.12%+
How Well Doctors Communicate	96.10%	93.75%	95.39%
Customer Service	85.00%+	81.82%+	87.74%+
Coordination of Care	87.50%+	81.25%+	80.77%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

CCHA Region 6: Strengths

The following measures' FY 2023–2024 scores for CCHA Region 6 were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for CCHA Region 6 were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*

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

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

The following measures' FY 2023–2024 scores for CCHA Region 6 were lower, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for CCHA Region 6 were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends CCHA Region 6 consider:

- Obtaining feedback from parents/caretakers of child members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Involving staff members at every level to assist in improving parents'/caretakers' of child members experiences.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions.

Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child members perspectives.

- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Exploring ways to direct parents/caretakers of child members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, CCHA Region 6 reported engaging in the following QI initiatives:

- Timeline information was shared with providers via the CCHA newsletter, practice transformation coaches, care coordinators, and community health strategists.
- Results of the CAHPS survey were communicated to providers and best practices related to access to care, patient-centered communication, and focused interventions were shared.
- In response to the declining customer services scores noted in the 2023 survey, CCHA worked to better understand its members' experiences.
- CCHA shared data with practices that were surveyed and worked with it QI teams to implement and build on existing interventions. Based on the categories with the lowest scores, CCHA started with improvement efforts focused on patient-centered communication and coordinating medical care.
- Successful interventions and/or best practices identified were shared across all preventive care management programs, as appropriate.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 CAHPS Recommendations

HSAG has determined that CCHA Region 6 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with CCHA Region 6.

QUIP

Table 4-100 presents CCHA Region 6's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-100—Summary of CCHA Region 6 QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Psychotherapy Services	Place of Service	83%	100%	100%	100%
Residential Services	Place of Service	88%	100%	100%	100%

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

CCHA Region 6: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- The data element in both service categories started with a baseline percent in the 80s, surpassed the 90 percent threshold by achieving 100 percent accuracy in month one, and sustaining 100 percent accuracy in months two and three.
- Key interventions for the QUIP consisted of additional training and education on place of service documentation requirements and how to make updates to the current EHR system.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- CCHA Region 6 reported that low accuracy results were due to two key failure modes: the provider and the coder. Provider issues included not documenting the accurate service location due to lack of training on how to select the service location.
- CCHA Region 6 reported that coders incorrectly entered the place of service due to a service not having a designated place of service code option.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that CCHA Region 6 continue to maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 QUIP Recommendations

CCHA Region 6 reported ongoing efforts to review service claims to identify providers that may benefit from additional assistance. CCHA Region 6 worked with identified providers to notify them of investigation findings and collaboratively work to enhance compliance with billing requirements and reduce the number of denied claims. CCHA Region 6 stated that it utilizes CAPs as needed to provide the structure, clarity of expectations, and accountability for established improvement efforts. CCHA Region 6 has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that the ongoing efforts to review service claims and the offer to train and educate providers is likely to improve and maintain encounter accuracy scores.

Mental Health Parity Audit

Table 4-101 displays the MHP Audit compliance scores for CCHA Region 6 for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-101—FY 2023–2024 MHP Audit Score for CCHA Region 6

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
CCHA	6	97%	Inpatient	95%	96%v
			Outpatient	96%	

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

CCHA Region 6: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 used MCG UR criteria for all MH determinations and ASAM LOC criteria for all SUD determinations.
- CCHA Region 6 required its UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- CCHA Region 6 made the denial determinations within the required time frame, and providers were notified of the denial determinations by telephone, secure email, fax, and/or a copy of the NABD within the required time frame.
- In all cases reviewed, the denial determination was made by a qualified clinician, and requesting providers were offered a peer-to-peer review.
- CCHA Region 6 demonstrated it followed its policies and procedures in attempting to reach out to the requesting provider for additional information in the applicable cases.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in CCHA Region 6's UM system.
- The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from CCHA Region 6 in filing, access to pertinent records, and a reason for the denial.
- During the MHP interview, CCHA Region 6 staff members reported collaboration with CCHA Region 6's Member Advisory Committee about attempting to help members understand the UM process, the care being provided, and the quality of care, regardless of whether the member receives care from the PH or the BH side. UM staff members also reported conducting a "UM 101" presentation that was member-friendly and explained what UM does and the background process so that members could understand CCHA Region 6's process when there is a request for service(s). Additionally, CCHA Region 6 brought in its grievance and appeal department to help the members further understand the grievance process.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- In multiple instances, CCHA Region 6 did not send the NABD to the member within the required time frame.

- While the NABDs included the required content, such as the member's appeal rights and the reason for the denial, one inpatient ASAM SUD denial did not include the complete list of the required ASAM dimensions and how each dimension was considered when determining medical necessity.
- All requesting providers were offered a peer-to-peer review; however, in four cases, peer-to-peer with the requesting provider occurred after the denial determination and the NABD was issued to the member.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Enhance monitoring mechanisms to ensure that the member is sent the NABD within the required time frame or use extensions, if needed, to meet compliance.
- Provide further training and oversight to ensure that the NABDs include each of the required ASAM dimensions in the inpatient SUD NABDs.
- Continue to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered peer-to-peer review prior to the issuance of the member NABD.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 6:

- Enhance monitoring mechanisms to ensure the member is informed of the denial determination within the required time frame.
- Include each of the required ASAM dimensions in the inpatient SUD NABDs and continue to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA Region 6 should update the applicable document to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continue to enhance easy-to-understand language and ensure that NABDs are member-friendly, such as using numbers instead of Roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA Region 6 should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 MHP Recommendations

CCHA Region 6 reported addressing HSAG's recommendations by:

- Implementing trainings on UM topics such as extensions and providing individual feedback to UM staff members during one-on-one check-ins with UM leadership. Additionally, CCHA Region 6 reported conducting monthly staff trainings on NABD time frame requirements and monitoring

timelines of the denial determination through monthly reports which are distributed to all UM staff members.

- Conducting trainings with medical directors to include all six ASAM dimensions within the inpatient SUD NABDs and notifying the medical directors of missing language during audits to ensure compliance. Additionally, CCHA Region 6 reported continuing to partner with the Department and other RAEs to ensure that there is consistency within the NABD language regarding the ASAM dimensions.
- Developing audits that include oversight of UM records to ensure the medical director's denial rationale is documented.

CCHA Region 6 still has the opportunity to address HSAG's recommendation of enhancing monitoring mechanisms to ensure the member is sent the NABD within the required time frame and including the required ASAM dimensions within inpatient SUD NABDs. CCHA Region 6's reported updates will most likely demonstrate improvement to overall UM processes. CCHA Region 6 should continue addressing the recommendations made by HSAG for continuous improvement, staff development, and to increase MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, CCHA Region 6 investigated 71 potential QOCG cases. CCHA Region 6's average membership in CY 2023 was 186,450, with 157,046 members enrolled as of December 31, 2023. CCHA Region 6 submitted 10 records for review; however, during the review process it was discovered that one record was incorrectly attributed to CCHA Region 6. Of the nine QOCG cases submitted by CCHA Region 6, all cases were substantiated.

CCHA Region 6: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- When a potential QOCG is received, CCHA Region 6 notifies the provider or facility being investigated, regardless of the referral source. HSAG recognizes this as a best practice.
- The policies and procedures outlined how CCHA Region 6 staff members may reach out to members to ensure that their immediate healthcare needs are being met. During the interview, CCHA Region 6 reported that member follow-up occurs through the care coordination department. The documents submitted for follow-up after the interview showed that CCHA Region 6 conducted or coordinated outreach attempts to members in all cases. HSAG identifies this as a best practice.
- CCHA Region 6 submits a quarterly report to the Department that includes a description of all QOCGs by type and severity. During the interview, CCHA Region 6 staff members shared that as of September 2023 they have been submitting the Department's QOCG form within two business days of receiving a QOCG.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- The policies and procedures stated that CCHA Region 6 will resolve QOCG issues "within a timely manner" but did not specify a required time frame. CCHA Region 6 staff members stated that their goal is to succeed at meeting the Department QOC time frame requirements and complete a review that safely resolves QOCGs.
- CCHA Region 6 tracks all QOCGs, record requests, and letters in internal Microsoft Excel spreadsheets as opposed to an integrated software system.

To address these opportunities, HSAG recommends that CCHA Region 6:

- Establish and implement a time frame and/or goals for the timeliness of the QOCG process.
- Explore and consider an electronic tracking system or EHR software add-on for QOCGs with the potential of enhanced functionality for tracking, trending, and following up on requirements during the QOCG process.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023; however, CCHA Region 6 reported ongoing QI efforts to address the FY 2021–2022 recommendations.

Review and Assessment of CCHA Region 6's Approach to Addressing FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

CCHA Region 6 reported addressing HSAG's recommendations by:

- Updating QOC policy information to include the definition of a "QOC concern" and time frames for investigating and processing.
- Tracking member information such as race, ethnicity, and disability status for every QOC logged.
- Notifying the Department about cases posing clear clinical risks as the cases are reported, and providing updates of any corrective actions taken and case resolution.

CCHA Region 6 reported additional updates to address statewide recommendations such as:

- Providing CCHA Region 6's credentialing department with annual data per provider when a QOCG has been substantiated (Level 3 and above).
- Updating CCHA Region 6's QOC policy to delineate that care coordinators may outreach members to determine if healthcare needs are being met.
- Conducting staff member training on the Colorado-specific QOC grievance process.

- Sending acknowledgement and resolution letters to members/member advocates.

HSAG anticipates CCHA Region 6's responses to the recommendations are likely to improve overall processes. CCHA Region 6 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

EPSDT Audit

Table 4-102 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-102—FY 2023–2024 EPSDT Audit Findings for CCHA Region 6

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	50%	75%
Post-Denial Record Review	92%	58%	75%

CCHA Region 6: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- CCHA Region 6 considered the EPSDT definition of "medical necessity" in most instances within the denial records reviewed.
- Multiple sections of the CCHA BH manual demonstrated best practices in customer service and adherence to EPSDT policies.
- All 15 denial cases reviewed were sent an NABD using the Department's template.
- The CCHA BH Manual detailed how CCHA Region 6 works with the Department to provide EPSDT services, and documentation regarding Escalated Case Review meetings described a process for CCHA Region 6 to send a spreadsheet to the Department weekly.
- The Annual Plan demonstrated thoughtful analysis of outreach data and outcomes that indicated that for CCHA Region 6 members, the most effective outreach occurred on Mondays and Wednesdays, whereas Thursday and Friday outreach efforts could potentially result in weekend engagement from members, which had less engagement opportunities to connect live with members of CCHA Region 6 staff, and this was recognized as a best practice.

- CCHA Region 6 attempted annual non-utilizer outreach for all 15 records. 
- CCHA Region 6's procedure to seek feedback from the MEAC regarding member outreach was determined to be a best practice. 

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- The 11 denial cases reviewed for medical necessity were all found to have considered most parts of the EPSDT definition of "medical necessity." 
- All medical necessity denials reviewed demonstrated that UM staff members utilized MCG and ASAM criteria, neither of which explicitly considered EPSDT within the review process. 
- An administrative denial reviewed demonstrated the denial was due to a noncovered diagnosis, but there was no explanation within the case as to how the physician determined that the intellectual disability was the primary diagnosis driving the behavior of the member. 
- CCHA Region 6 staff members reported only recently introducing Spanish text messaging. 
- Multiple cases reviewed showed that members who only received one non-utilizer outreach attempt were all contacted through a mailed letter, and CCHA Region 6 did not have a mechanism for tracking returned mail. 

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Continue to improve the utilization review process for documentation of CCHA Region 6's consideration for providing a safe environment for members, especially related to discharge plans.
- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to MCG or ASAM, prior to issuing a denial.
- Implement standard processes and documenting if the member's intellectual developmental disability (IDD), a neurological or neurocognitive disorder, or traumatic brain injury is the driving factor for the symptoms being treated.
- Assess its outreach methods and ensure that outreach is available in Spanish across all methods.
- Consider assessing the amount of returned mail CCHA Region 6 receives if only mailed letter outreach is going to be utilized.

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 6:

- Consider adding an EPSDT flyer to notices for members within the eligible age range that includes information about assistance with scheduling appointments and transportation.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 EPSDT Recommendations

CCHA Region 6 reported addressing HSAG's recommendation by:

Creating new NABD denial language that identifies the recommended LOC along with the number to CCHA Region 6's member support call center line to assist the member in finding new providers recommended for the appropriate LOC. Additionally, adding language into multiple UM desktop procedures to emphasize the recommended LOC as well as members' access to CCHA Region 6's member support call center.

- Updating UM desktop processes related to noncovered diagnoses when reviewing cases and providing quarterly and ad hoc trainings on the UM desktop procedures.
- Introducing a desktop guide to clarify roles and streamline the authorization process for care coordination and UM staff members, including handling denials and appeals, to minimize duplication efforts and ensure consistent communication with CCHA Region 6 staff members and external stakeholders.
- Partnering with the psychological testing team to refer members who receive an administrative denial for psychological and neuropsychological testing to ensure parents/guardians are educated on alternative potential funding options such as FFS and EPSDT.
- Creating a UM process to refer members who have used psychiatric residential treatment facility (PRTF) or qualified residential treatment program (QRTP) for outreach and care coordination when the member is not already assigned a care coordinator.
- Implementing a nurse-outreach initiative to high-risk pregnancy members who were previously outreach by the call center staff team. Additionally, refining the complex member definition and outreach process to ensure all members defined as "complex" receive outreach upon enrollment and every six months after if services are refused or if CCHA Region 6 is unable to contact the member.
- Creating a contingency plan for EPSDT new member outreach when CCHA Region 6 does not receive timely newly enrolled member files or does not receive a comprehensive dataset in the files provided.

CCHA Region 6's reported updates will likely demonstrate improvement to overall UM processes. CCHA Region 6 should continue to address the recommendations by HSAG to improve member communication and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-103 displays the percentage of cases reviewed that HSAG's reviewers determined adhered to ASAM criteria.

Table 4-103—CCHA Region 6 Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
CCHA Region 6	42	38[1]	34	89%

[1] *Four samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 38.*

Table 4-104 presents the number of cases in the sample that HSAG reviewed for CCHA Region 6 and the percentage of cases in which HSAG's reviewers agreed with CCHA Region 6's denial determination.

Table 4-104—CCHA Region 6 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
CCHA Region 6	42	38[1]	36	95%

[1] *Four samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 38.*

CCHA Region 6: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 6:

- All 42 cases reviewed indicated the member received an NABD after CCHA Region 6's denial determination, demonstrating 100 percent compliance, which was a notable improvement since the last review period.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations.
- Although it is best practice for facilities to begin discharge planning upon the member's admission, many cases demonstrated a delay in discharge planning, resulting in members being denied additional coverage without a stable discharge plan, which increased relapse risk.

To address these opportunities for improvement, HSAG recommends CCHA Region 6:

- Provide training for providers and UM reviewers on the importance of considering the member's interdimensional interactions and co-occurring problems in the review process.
- Provide additional training for providers regarding discharge planning as well as using care coordination and other available resources to provide assistance with discharge planning and continuity of care.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that CCHA Region 6:

- Update policies, procedures, and processes to ensure that members and providers are notified about the denial decision in a timely manner.
- Develop and use an NABD template to ensure that member communications regarding adverse benefit determinations include a description of the medical necessity criteria and each ASAM dimension.

Assessment of CCHA Region 6's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

CCHA Region 6 reported addressing HSAG's recommendations by:

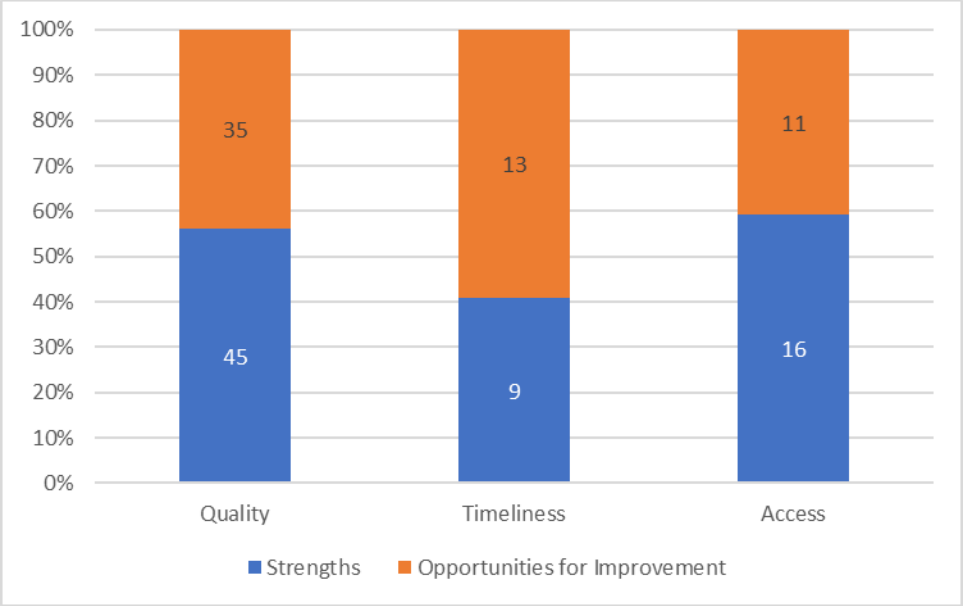
- Conducting monthly staff trainings regarding the NABD turnaround time frame.
- Ensuring monthly turnaround time reports are sent to all UM associates to monitor timeliness of the denial determination within the required time frame.
- Providing training with medical directors to include all six dimensions within the NABD.
- During audits, notifying medical directors of missing language to ensure compliance.

- Conducting monthly and/or quarterly collaboration meetings with high-volume SUD providers on ASAM trainings and resources on the CCHA website, Department resources, and resources directly from ASAM.
- Using the CCHA provider newsletter to communicate updates regarding the SUD benefit and resources for ASAM trainings.

HSAG anticipates CCHA Region 6's responses to the recommendations are likely to improve overall processes, communication with members, and compliance with State and federal regulations. CCHA Region 6 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

Region 7—Colorado Community Health Alliance

Figure 4-7—Number of Strengths and Opportunities for Improvement by Care Domain for CCHA Region 7*



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

The following are CCHA Region 7's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment related to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

CCHA Region 7 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP and the nonclinical *Social Determinants of Health (SDOH) Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. On initial submission, the *FUH* PIP received an overall *Low Confidence* level, and the *SDOH Screening* PIP received an overall *High Confidence* level. CCHA Region 7 resubmitted both PIPs and received an overall *High Confidence* level for the final validation. Table 4-105 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *FUH*

Table 4-105—2023–2024 PIP Overall Confidence Levels for the *FUH* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	88%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *FUH* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. CCHA Region 7 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-106—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. CCHA Region 7 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *FUH*

Table 4-107 displays data for CCHA Region 7's *FUH* PIP.

Table 4-107—Performance Indicator Results for the *FUH* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for CCHA Region 7 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.	N: 827 D: 2,007	41.21%					

N–Numerator D–Denominator

For the baseline measurement period, CCHA Region 7 reported that the percentage of discharges for CCHA Region 7 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 was 41.21 percent.

Nonclinical PIP: *SDOH Screening*

Table 4-108 displays data for CCHA Region 7's *SDOH Screening* PIP.

Table 4-108—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 618 D: 2,526	24.47%					

N–Numerator D–Denominator

For the baseline measurement period, CCHA Region 7 reported that 24.47 percent of BHTOC members attributed to Region 7 with new BHTOC and STOC cases were screened for unmet food, housing, utility, and transportation needs.

Interventions

Clinical PIP: *FUH*

Table 4-109 displays the barriers and interventions documented by the health plan for the *FUH* PIP.

Table 4-109—Barriers and Interventions for the *FUH* PIP

Barriers	Interventions
• No process for Diversus Health to support aftercare engagement for members who are not open to the Center at the time of inpatient hospitalization. • No process to notify CCHA of the member's enrollment status with Diversus Health at the time of inpatient placement. • No standardized process to verify and ensure members' successful transition to outpatient care. • No process to verify and/or obtain up-to-date contact information for members for effective outreach and engagement efforts. • No alternative process to schedule follow-up services if direct member outreach is unsuccessful or permission to outreach is denied. • No process to document, calculate, or routinely review rates of follow-up within 7 days from discharge from inpatient placement.	Establish a process to coordinate discharge and BH follow-up service within 7 days for eligible members transitioning out of psychiatric inpatient hospitalization.

Nonclinical PIP: *SDOH Screening*

Table 4-110 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-110—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and ATU for a BH condition, or high levels of care for a SUD event.	Standardize requirements for screening CCHA members enrolled in BHTOC and STOC programming for unmet food, housing, utility, and transportation needs.

CCHA Region 7: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- CCHA Region 7 reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

CCHA Region 7: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. CCHA Region 7 addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and CCHA Region 7 received *High Confidence* for the final Module 4 submission. CCHA Region 7's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Performance Measure Rates and Validation

Table 4-111 shows the performance measure results for CCHA Region 7 for MY 2021 through MY 2023.

Table 4-111—Performance Measure Results for CCHA Region 7

Performance Measure	MY 2021	MY 2022	MY 2023	MY 2023 Performance Target
Engagement in Outpatient SUD Treatment	54.10%	61.25%	56.05%	59.51%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	41.42%	32.49%	33.90%	77.47%
Follow-Up Within 7 Days of an ED Visit for SUD	32.75%	31.97%	32.15%	40.14%
Follow-Up After a Positive Depression Screen	73.39%	64.85%	59.70%	95.80%
Behavioral Health Screening or Assessment for Children in the Foster Care System	23.29%	16.06%	15.73%	36.42%

CCHA Region 7: Strengths

The following performance measure rates for MY 2023 increased from the previous year for CCHA Region 7:

- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*
- *Follow-Up Within 7 Days of an ED Visit for SUD*

For MY 2023, none of the measure rates exceeded the established performance measure target.

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

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

- *Engagement in Outpatient SUD Treatment*
- *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*

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

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[32]

Follow-Up on FY 2022–2023 Performance Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 7:

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

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 Performance Measure Recommendations

Based on the recommendations provided by HSAG, CCHA Region 7 reported implementing the following:

- Detailed review of all provided performance data to promote accuracy and congruence with internally calculated projections. Providers are routinely notified of pertinent measure rates to gauge performance and intervention opportunities.
- A partnership with the CMHCs on PIPs to define and enhance clinical pathways to support clients' transition from inpatient placements. CCHA care coordinators as well as CMHC staff members work with members and facilities to establish timely BH follow-up services post-discharge.

HSAG recognizes that the CCHA's focus on monitoring performance data and data sharing, as well as its partnerships and support to providers, are likely to help improve and maintain performance rates.

[32] Ibid.

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 7 Overall Evaluation

Table 4-112 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-112—Summary of CCHA Region 7 Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%~
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**53**	**1**	**0**	**0**	**98%**

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

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

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

~ *Indicates no change from review three years prior.*

CCHA Region 7: Trended Performance for Compliance With Regulations

Table 4-113 presents, for all standards, the overall percentage of compliance score for CCHA Region 7 for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-113—Compliance With Regulations—Trended Performance for CCHA Region 7

Standard and Applicable Review Years	CCHA Region 7 Average—Previous Review	CCHA Region 7 Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	87%	94%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	94%	100%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	100%	90%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**87%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	74%	74%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**100%**	**100%**
Standard VIII—Credentialing and Recredentialing (2020–2021)	NA**	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**100%**	**75%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	75%	86%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard VIII—Credentialing and Recredentialing, to align Medicaid and CHP+ reviews and avoid duplication of efforts across LOBs, compliance with federal Provider Selection requirements, including credentialing and recredentialing, were evaluated through Standard VII—Program Selection and Program Integrity.*
****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, CCHA Region 7 demonstrated consistently moderate to high-achieving scores for three out of four standards, of which two standards maintained scores of 100 percent from the previous review cycle. Most notably, Standard V—Member Information Requirements increased by 13 percentage points, demonstrating a general to strong understanding of most federal and State regulations.

CCHA Region 7: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CPGs were reviewed and discussed during the advisory committee before they were adopted and made available to both providers and members on the website.

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

HSAG found the following opportunities for improvement:

- Some written agreements did not include all of the required language.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Revise or amend the written agreements to include the required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 7:

- Enhance its messaging to members in a way that encourages members to express grievances freely without the barrier of a perceived second "formal" step. Additionally, update and conduct a refresher training that reiterates the enhanced messaging to members who are expressing dissatisfaction.
- Update the documents located on the website to accurately state that a grievance acknowledgement letter will be sent to the member within two working days.
- Modify documents located on the website to remove the statement that a verbal appeal must be followed up with a written appeal and update its appeal acknowledgement letters to remove any requirement that the member must follow up with a verbal appeal in writing.
- Improve monitoring of appeal acknowledgment timeliness to ensure that CCHA is meeting the time frame set forth by the State contract and federal regulations.
- Ensure that all appeal acknowledgement letters accurately identify the correct time frame for the resolution of an appeal.
- Update the member appeals policy to include that a member may file a grievance if they disagree with the appeals decision.
- Enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of a member, an extension letter is sent to the member, and they are given prompt oral notice of the delay.

- Update the appeal resolution letter to include the RAE's contact phone number and remove "written" from the appeal resolution letter with regard to continuation of benefits.
- Update its BH provider manual to remove inaccurate language such as appeal information under the grievance section and requiring the member to attach documentation, as well as add language that the MCE will make reasonable effort to provide oral notice of resolution in the case of an expedited appeal.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, CCHA Region 7 updated the BH provider manual, appeal policies, appeal resolution letters, and other policies and procedures to come into compliance with the recommendations. In addition, CCHA Region 7 updated and conducted a refresher training that reiterates the enhanced messaging to members who express dissatisfaction. CCHA Region 7 enhanced policies, procedures, and training for staff members to ensure that for members who request an extension, or an extension is needed in the best interest of the member, an extension letter is sent to the member, and members are given prompt oral notice of the delay. HSAG recognizes that updating multiple documents including provider manuals, templates, and policies and procedures, is likely to result in long-term improvements.

Validation of Network Adequacy

CCHA Region 7: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 met the minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties. 
- CCHA Region 7 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 66.6 percent of contracted counties. In the counties where CCHA Region 7 failed to meet the minimum network requirements, access for both General and Pediatric SUD Treatment Practitioner was greater than 99.9 percent. 
- In the contracted counties where CCHA Region 7 did not meet minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) and Family Practitioner (MD, DO, NP, CNS, and PA), access ranged from 99 percent to greater than 99.9 percent of the minimum network requirement for all listed categories. 
- CCHA Region 7 maintained a thoroughly documented deliverable validation process, which included a RACI matrix that identified the responsible, accountable, consulted, and informed individuals for each phase of the deliverable. This documented process helped CCHA Region 7

ensure business continuity in its network adequacy reports and its ability to maintain detailed steps to ensure the accuracy of these submissions.

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

HSAG found the following opportunities for improvement:

- CCHA Region 7 did not meet the minimum network requirement for SUD Treatment Facilities across all ASAM LOCs in all contracted counties.
- CCHA Region 7 did not meet the minimum network requirement for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties, with access ranging from 39.8 percent to 97.9 percent in urban counties and 22.5 percent access in rural counties.
- CCHA Region 7 indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when CCHA Region 7 is informed of a change in member demographic information.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Conduct an in-depth review of provider categories for which CCHA Region 7 did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that CCHA Region 7 continue to conduct an in-depth review of provider categories for which CCHA Region 7 did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that CCHA Region 7:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.

- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, CCHA Region 7 should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the CCHA Region 7 data that could not be located in the online provider directory.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 NAV Recommendations

In response to HSAG's recommendation, CCHA Region 7 reported taking the following actions:

- Added ASAM facilities to the CCHA BH network to further improve compliance.
- At minimum, network adequacy validation reports and annual plans were reviewed by provider relations staff/network managers and leadership for oversight, monitoring, and feedback quarterly.
- Communicated expectations to BH providers regarding hours of operation. The CCHA Behavioral Health Provider Manual requires providers to post a statement in their offices detailing hours of operation. Provider office hours can vary due to the nature of BH services. CCHA verified directories and hours of operation were correct as indicated by providers.
- Reviewed the survey responses current as of the time of the audit to identify opportunities for improvement. The findings indicated two large provider groups with multiple office locations had staff who declined to participate during the survey, which was tracked as a noncompliant response. Both providers were outreached directly to discuss the survey and participation.

Based on the above response, CCHA Region 7 worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RAE 411 Over-Read

Table 4-114 presents CCHA Region 7's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-114—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 7

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	86.9%	97.8%
Diagnosis Code	98.5%	94.2%	90.5%
Place of Service	NA	83.2%	96.4%
Service Category Modifier	NA	86.9%	97.8%
Units	NA	97.1%	95.6%
Revenue Code	97.1%	NA	NA
Discharge Status	97.1%	NA	NA
Service Start Date	98.5%	100.0%	96.4%
Service End Date	98.5%	100.0%	97.1%
Population	NA	100.0%	97.8%
Duration	NA	92.7%	97.8%
Staff Requirement	NA	99.3%	97.8%

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

Table 4-115 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with CCHA Region 7's EDV results for each of the validated data elements.

Table 4-115—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 7

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

Data Element	Inpatient Services (10 Over-Read Cases)	Psychotherapy Services (10 Over-Read Cases)	Residential Services (10 Over-Read Cases)
Population	NA	100.0%	100.0%
Duration	NA	100.0%	100.0%
Staff Requirement	NA	100.0%	100.0%

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

CCHA Region 7: Strengths

Based on RAE 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 self-reported high overall accuracy with 90 percent accuracy or above for all five inpatient services data elements, seven of the 10 psychotherapy services data elements, and all 10 residential services data elements.
- HSAG's over-read findings suggest a high level of confidence that CCHA Region 7's EDV results accurately reflect its encounter data quality.
- HSAG reported 100 percent agreement with all five inpatient services data elements, nine of the 10 psychotherapy services data elements, and all 10 residential services data elements.

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

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in CCHA Region 7's EDV results, CCHA Region 7's self-reported EDV results for psychotherapy services demonstrated a moderate level of encounter data accuracy, with an 83.2 percent accuracy rate for the *Place of Service* data element, and an 86.9 percent accuracy rate for the *Procedure Code* and *Service Category Modifier* data elements when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 7 consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

CCHA Region 7 reported continuous assessments and enhancements of its multifaceted approach to promote ongoing improvements to the accuracy of encounter data submissions. CCHA Region 7 reported utilizing website postings, sending a monthly News and Updates newsletter to providers, and regularly distributing a Behavioral Health Provider Bulletin. CCHA Region 7 additionally noted hosting a monthly Behavioral Health Provider Open Mic Call that serves as a forum to share updates, respond to providers' questions, and review mock audit exercises. CCHA Region 7 also reported disseminating routine updated guidelines to provide clarity on audit requirements, common mistakes, and provide a self-audit checklist. CCHA Region 7 also noted sharing practice-level scorecards with the providers' results for each audited element to guide necessary corrections. CCHA Region 7 noted referring findings indicative of substantial risk of improper billing to the Special Investigations Unit for further review, monitoring, and determination of required action. Additionally, CCHA Region 7 reported regular review of service claims to identify practices that may benefit from additional assistance. Additionally, CCHA Region 7 noted that Behavioral Health Practice Transformation Coaches work with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements to reduce the number of denied claims. Finally, CCHA Region 7 utilized CAPs to provide structure, clarity of expectations, and accountability for established improvement efforts.

Based on CCHA Region 7's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

CAHPS Survey

CCHA Region 7: Adult CAHPS

Table 4-116 shows the adult CAHPS results for CCHA Region 7 for FY 2021–2022 through FY 2023–2024.

Table 4-116—Adult CAHPS Results for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	48.18%	51.08%	43.44% ↓
Rating of All Health Care	48.98%+	50.52%+	47.62%+
Rating of Personal Doctor	55.66%	62.04%	62.89%+
Rating of Specialist Seen Most Often	72.58%+	68.83%+	63.49%+
Getting Needed Care	80.79%+	81.13%+	79.00%+
Getting Care Quickly	77.53%+	80.88%+	75.61%+
How Well Doctors Communicate	92.84%+	93.74%+	90.43%+
Customer Service	92.19%+	82.61%+	93.90%+ ▲
Coordination of Care	78.85%+	85.96%+	81.48%+
Advising Smokers and Tobacco Users to Quit	72.73%+	69.57%+	66.67%+
Discussing Cessation Medications	31.25%+	37.31%+	41.94%+
Discussing Cessation Strategies	42.42%+	42.65%+	44.07%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

CCHA Region 7: Strengths

The following measure's FY 2023–2024 score for CCHA Region 7 was higher, although not statistically significantly, than the 2023 NCQA national average:

- *Customer Service*

The following measure's FY 2023–2024 score for CCHA Region 7 was statistically significantly higher than the FY 2022–2023 score:

- *Customer Service*

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

The following measure's FY 2023–2024 score for CCHA Region 7 was statistically significantly lower than the 2023 NCQA national average:

- *Rating of Health Plan*

The following measures' FY 2023–2024 scores for CCHA Region 7 were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Coordination of Care*
- *Advising Smokers and Tobacco Users to Quit*

To address these low CAHPS scores, HSAG recommends CCHA Region 7 consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.
- Obtaining feedback from members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Involving staff members at every level to assist in improving the member experience.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with members. Specialists could ask questions about members' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their condition and the actions they will take to monitor and manage members' conditions in the future, as well as follow up with any concerns that members might have about their healthcare.
- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.

- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Obtaining and analyzing members' experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers.
- Providing internal training sessions and sending out newsletters designed to educate providers on the importance of guiding and advising smokers and tobacco users to quit. The training could emphasize the importance of doctors speaking directly to their members about quitting. It can provide information and advice on speaking to members about potential long-term health implications related to tobacco use, strategies for tobacco cessation, and educating the patients on long-term health outcomes if they continue tobacco use versus tobacco cessation.

CCHA Region 7: General Child CAHPS

Table 4-117 shows the general child CAHPS results for CCHA Region 7 for FY 2021–2022 through FY 2023–2024.

Table 4-117—General Child CAHPS Results for CCHA Region 7

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	66.13%	58.10%	59.51% ↓
Rating of All Health Care	61.95%	54.76%	56.31% ↓
Rating of Personal Doctor	75.00%	69.23%	71.74%
Rating of Specialist Seen Most Often	62.16%+	72.00%+	57.50%+
Getting Needed Care	70.55%+	73.94%+	75.08%+
Getting Care Quickly	83.64%+	78.53%+	83.59%+
How Well Doctors Communicate	94.01%	89.65%	94.89%+
Customer Service	86.76%+	85.02%+	90.63%+
Coordination of Care	75.00%+	77.78%+	80.43%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present RAE-level results in this report.

CCHA Region 7: Strengths

The following measures' FY 2023–2024 scores for CCHA Region 7 were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *How Well Doctors Communicate*
- *Customer Service*

The following measures' FY 2023–2024 scores for CCHA Region 7 were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measures' FY 2023–2024 scores for CCHA Region 7 were statistically significantly lower than the 2023 NCQA national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*

The following measure's FY 2023–2024 score for CCHA Region 7 was lower, although not statistically significantly, than the FY 2022–2023 score:

- *Rating of Specialist Seen Most Often*

To address these low CAHPS scores, HSAG recommends CCHA Region 7 consider:

- Obtaining feedback from parents/caretakers of child members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.

- Involving staff members at every level to assist in improving parents'/caretakers' of child members experiences.
- Any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with the parents/caretakers of child members. Specialists could ask questions about parents'/caretakers' of child members concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, CCHA Region 7 reported engaging in the following QI initiatives:

- Timeline information was shared with providers via the CCHA newsletter, practice transformation coaches, care coordinators, and community health strategists.
- Results of the CAHPS survey were communicated to providers and best practices related to access to care, patient-centered communication, and focused interventions were shared.
- In response to the declining customer services scores noted in the 2023 survey, CCHA worked to better understand its members' experiences.
- CCHA shared data with practices that were surveyed and worked with its QI teams to implement and build on existing interventions. Based on the categories with the lowest scores, CCHA started with improvement efforts focused on patient-centered communication and coordinating medical care.
- Successful interventions and/or best practices identified were shared across all preventive care management programs, as appropriate.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 CAHPS Recommendations

HSAG has determined that CCHA Region 7 addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with CCHA Region 7.

QUIP

Table 4-118 presents CCHA Region 7's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-118—Summary of CCHA Region 7 QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Discharge Status	56%	100%	100%	100%
Psychotherapy Services	Place of Service	82%	100%	100%	100%

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

CCHA Region 7: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- The inpatient services *Discharge Status* data element started with a baseline of 56 percent, improved above the 90 percent threshold in month one, and sustained 100 percent accuracy in months two and three.
- The psychotherapy services *Place of Service* data element started with a baseline of 82 percent, improved above the 90 percent threshold in month one, and sustained 100 percent accuracy in months two and three.
- CCHA Region 7 reported multiple key interventions for the QUIP, which consisted of additional training, regular audits to verify the accuracy of documentation, "cross walking" data from the local software against the corporate networks for quick identification of inaccuracies, education about *Place of Service* documentation requirements, and the pilot partner updating the patient accounting software to ensure that the disposition type transfers to the claim form.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QUIP

HSAG found the following opportunities for improvement:

- CCHA Region 7 reported that low accuracy results were due to IT updates to the software system disrupting the automatic transfer of disposition field data.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that CCHA Region 7 maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates remain above the 90 percent threshold.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 QUIP Recommendations

CCHA Region 7 reported ongoing efforts to review service claims to identify providers that may benefit from additional assistance. CCHA Region 7 worked with identified providers to notify them of investigation findings and collaboratively work to enhance compliance with billing requirements and reduce the number of denied claims. CCHA Region 7 stated that it utilizes CAPs as needed to provide the structure, clarity of expectations, and accountability for established improvement efforts. CCHA Region 7 has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that the ongoing efforts to review service claims and the offer to train and educate providers is likely to improve and maintain encounter accuracy scores.

Mental Health Parity Audit

Table 4-119 displays the MHP Audit compliance scores for CCHA Region 7 for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-119—FY 2023–2024 MHP Audit Score for CCHA Region 7

RAE	Region	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD Services					
CCHA	7	92%	Inpatient	94%	95%^
			Outpatient	96%	

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

CCHA Region 7: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 demonstrated an overall score of 95 percent.
- CCHA Region 7 used MCG UR criteria for all MH UR determinations and ASAM LOC criteria for all SUD determinations.
- CCHA Region 7 required its UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- CCHA Region 7 made the denial determinations within the required time frame, and providers were notified of the denial determinations by telephone, secure email, fax, and/or received a copy of the NABD within the required time frame in most records reviewed.
- Within one case reviewed, CCHA Region 7 used an extension, and the extension letter was sent to the member within the required time frame and included the required content.
- In all cases reviewed, the denial determination was made by a qualified clinician.
- In all applicable cases except one, the records contained evidence that a peer-to-peer review was offered to requesting providers.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in CCHA Region 7's UM system.
- The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from CCHA Region 7 in filing an appeal, access to pertinent records, and a reason for the denial.
- During the MHP interview, CCHA Region 7 staff members reported collaboration with CCHA Region 7's Member Advisory Committee about attempting to help members understand the UM process, the care being provided, and the quality of care, regardless of whether the member receives care from the PH or the BH side. UM staff members also reported conducting a "UM 101" presentation that was member-friendly and explained what UM does and the background process so that members could understand CCHA Region 7's process when there is a request for service(s). Additionally, CCHA Region 7 brought in its grievance and appeal department to help the members further understand the grievance process.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the MHP Audits

HSAG found the following opportunities for improvement:

- In multiple instances, CCHA Region 7 did not notify the requesting provider of the denial and send the NABD to the member within the required time frame.
- While the NABDs included the required content, such as the member's appeal rights and the reason for the denial, two inpatient ASAM SUD denials did not include the complete list of the required ASAM dimensions and how they were considered when determining medical necessity.
- Within one case, there was no evidence that peer-to-peer review with the requesting provider was offered by CCHA Region 7. Additionally, in one case, peer-to-peer occurred after the denial determination and issuance of the NABD to the member.
- CCHA Region 7 did not reach out to the requesting provider for additional documentation to determine medical necessity in one record reviewed.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Enhance monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.
- Provide further training and oversight to ensure that the NABDs include each of the required ASAM dimensions in the inpatient SUD NABDs.
- Continue to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered peer-to-peer review prior to the issuance of the member NABD.
- Enhance monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 7:

- Enhance monitoring mechanisms to ensure the provider and member are informed of the denial within the required time frame.
- Follow establish policies and procedures to ensure requesting providers are consistently offered peer-to-peer review. Additionally, HSAG recommends revising the *UM Program Description* document to ensure consistency between CCHA Region 7's written policies, program descriptions, and organizational processes.

- Include each of the required ASAM dimensions in the inpatient SUD NABDs and continue to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA Region 7 should update the applicable documents to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continue to enhance easy-to-understand language and ensure that NABDs are member-friendly, such as using numbers instead of Roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA Region 7 should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 MHP Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by:

- Conducting monthly staff trainings on NABD time frame requirements and sending monthly reports to UM staff members to monitor timeliness of the denial determination within the required time frame. Additionally, CCHA Region 7 reported introducing a desktop guide that was created by CCHA Region 7's care coordination and UM departments to clarify roles and streamline the authorization process, including handling denials and appeals. The desktop guide was created to minimize duplication and ensure consistent communication within the organization and with external stakeholders.
- Updating the *UM Program Description* document to ensure peer-to-peer reviews are offered with every denial determination and conducting quarterly trainings with UM staff members regarding UM desktop procedures to ensure consistency.
- Conducting trainings with medical directors to include all six ASAM dimensions within the inpatient SUD NABDs and notifying the medical directors of missing language during audits to ensure compliance. Additionally, continuing to partner with the Department and other RAEs to ensure that there is consistency within the NABD language regarding the ASAM dimensions.
- Developing audits that include oversight of UM records to ensure the medical director's denial rationale is documented.

CCHA Region 7 still has the opportunity to address HSAG's recommendation of enhancing monitoring mechanisms to ensure the provider is notified of the denial and member is sent the NABD within the required time frame, ensuring providers are consistently offered a peer-to-peer review prior to issuing an NABD, and including each of the required ASAM dimensions within the inpatient SUD NABDs. CCHA Region 7's reported updates will most likely demonstrate improvement to overall UM processes. CCHA Region 7 should continue addressing the recommendations made by HSAG for continuous improvement, staff development, and to increase MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, CCHA Region 7 investigated 35 potential QOCG cases. CCHA Region 7's average membership in CY 2023 was 213,239, with 179,470 members enrolled as of December 31, 2023. Of the 10 QOCG cases investigated by CCHA Region 7, all cases were substantiated.

CCHA Region 7: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- When a potential QOCG is received, CCHA Region 7 notifies the provider or facility being investigated, regardless of the referral source. HSAG recognizes this as a best practice.
- The policies and procedures outlined how CCHA Region 7 staff members may reach out to members to ensure that their immediate healthcare needs are being met. During the interview, CCHA Region 7 reported that member follow-up occurs through the care coordination department. The documents submitted for follow-up after the interview showed that CCHA Region 7 conducted or coordinated outreach attempts to members in all cases. HSAG identifies this as a best practice.
- CCHA Region 7 submits a quarterly report to the Department that includes a description of all QOCGs by type and severity. During the interview, CCHA Region 7 staff members shared that as of September 2023 they have been submitting the Department's QOCG form within two business days of receiving a QOCG.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- The policies and procedures stated that CCHA Region 7 is to resolve QOCG issues "within a timely manner" but did not specify a required time frame. During the interview, CCHA Region 7 staff members stated that their goal is to succeed at meeting the Department QOC time frame requirements and complete a review that safely resolves QOCGs.
- CCHA Region 7 tracks all QOCGs, record requests, and letters in internal Microsoft Excel spreadsheets.
- Three of the 10 sample cases were submitted by CCHA Region 7 staff members on behalf of a member. Only one case included evidence of the member receiving a grievance notification and resolution letter within the required time frames.

To address these opportunities, HSAG recommends that CCHA Region 7:

- Establish and implement a time frame and/or goals for the timeliness of the QOCG process.
- Explore and consider use of an electronic tracking system or EHR software add-on for QOCGs with the potential of enhanced functionality for tracking, trending, and following up on requirements during the QOCG process.
- Update policies and procedures to ensure that QOCGs originating from the member receive the appropriate acknowledgement and resolution letters.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023; however, CCHA Region 7 reported ongoing QI efforts to address the FY 2021–2022 recommendations.

Review and Assessment of CCHA Region 7's Approach to Addressing FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by:

- Updating QOC policy information to include the definition of a "QOC concern" and time frames for investigating and processing.
- Tracking member information such as race, ethnicity, and disability status for every QOC logged.
- Notifying the Department about cases posing clear clinical risks as the cases are reported, and providing updates of any corrective actions taken and case resolution.

CCHA Region 7 reported additional updates to address statewide recommendations such as:

- Conducting staff member training on the Colorado-specific QOC grievance process.
- Sending acknowledgement and resolution letters to members/member advocates.

HSAG anticipates CCHA Region 7's responses to the recommendations are likely to improve overall understanding of the Colorado specific QOCG process and improve overall policies and procedures. CCHA Region 7 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

EPSDT Audit

Table 4-120 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-120—FY 2023–2024 EPSDT Audit Findings for CCHA Region 7

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	38%	69%
Post-Denial Record Review	92%	63%	80%

CCHA Region 7: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- Multiple sections of the CCHA BH manual demonstrated best practices in customer service and adherence to EPSDT policies.
- All 15 denial cases reviewed were sent an NABD using the Department's template.
- The CCHA BH Manual detailed how CCHA Region 7 works with the Department to provide EPSDT services, and documentation regarding Escalated Case Review meetings described a process for CCHA Region 7 to send a spreadsheet to the Department weekly.
- Most denial cases reviewed demonstrated the member was already engaged in care coordination services at the time of the denial or was referred to care coordination services due to the denial of services. Additionally, in each of these referrals, care coordination outreached the member in a timely manner, documented multiple attempts and modalities of contact to outreach the member, and included documentation of providing EPSDT information to the member or member's family.
- The Annual Plan demonstrated thoughtful analysis of outreach data and outcomes that indicated that for CCHA Region 7 members, the most effective outreach occurred on Mondays and Wednesdays, whereas Thursday and Friday outreach efforts could potentially result in weekend engagement from members, which had less engagement opportunities to connect live with members of CCHA Region 7 staff, and this was recognized as a best practice.
- Of the 15 records reviewed, CCHA Region 7 attempted non-utilizer outreach for 13 records.

- CCHA Region 7's procedure to seek feedback from the MEAC regarding member outreach was determined to be a best practice.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the EPSDT Audits

HSAG found the following opportunities for improvement:

- There was no explicit documentation of how the EPSDT definition was considered within the denial records reviewed.
- All medical necessity denials reviewed demonstrated that UM staff members utilized MCG and ASAM criteria, neither of which explicitly considered EPSDT within the review process.
- CCHA Region 7 staff members reported only recently introducing Spanish text messaging.
- Multiple cases reviewed showed that members who only received one non-utilizer outreach attempt were all contacted through a mailed letter, and CCHA Region 7 did not have a mechanism for tracking returned mail.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Strengthen its UM procedures to ensure the full EPSDT definition of "medical necessity" is considered during the review process.
- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to MCG or ASAM, prior to issuing a denial.
- Assess its outreach methods and ensure that outreach is available in Spanish across all methods.
- Consider assessing the amount of returned mail CCHA Region 7 receives if only mailed letter outreach is going to be utilized.

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended CCHA Region 7:

- Consider adding an EPSDT flyer to notices for members within the eligible age range that includes information about assistance with scheduling appointments and transportation.
- Enhance efforts to refer between UM and care coordination, especially for noncovered services.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 EPSDT Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by:

- Creating new NABD denial language that identifies the recommended LOC along with the number to CCHA Region 7's member support call center line to assist the member in finding new providers recommended for the appropriate LOC. Additionally, adding language into multiple UM desktop procedures to emphasize the recommended LOC as well as members' access to CCHA Region 7's member support call center.
- Introducing a desktop guide to clarify roles and streamline the authorization process for care coordination and UM staff members, including handling denials and appeals, to minimize duplication efforts and ensure consistent communication with CCHA Region 7 staff members and external stakeholders.
- Partnering with the psychological testing team to refer members who receive an administrative denial for psychological and neuropsychological testing to ensure parents/guardians are educated on alternative potential funding options such as FFS and EPSDT.
- Updating UM desktop processes related to noncovered diagnoses when reviewing cases and providing quarterly and ad hoc trainings on the UM desktop procedures.
- Creating a UM process to refer members who have used PRTF or QRTP for outreach and care coordination when the member is not already assigned a care coordinator.
- Implementing a nurse-outreach initiative to high-risk pregnancy members who were previously outreach by the call center staff team. Additionally, refining the complex member definition and outreach process to ensure all members defined as "complex" receive outreach upon enrollment and every six months after if services are refused or if CCHA Region 7 is unable to contact the member.
- Creating a contingency plan for EPSDT new member outreach when CCHA Region 7 does not receive timely newly enrolled member files or does not receive a comprehensive dataset in the files provided.

CCHA Region 7's reported updates will likely demonstrate improvement to overall UM processes. CCHA Region 7 should continue to address the recommendations by HSAG to improve member communication and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-121 presents the number of cases in the sample that HSAG reviewed for CCHA Region 7 and the percentage of cases in which HSAG's reviewers agreed with CCHA Region 7's denial determination.

Table 4-121—CCHA Region 7 Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
CCHA Region 7	35	29[1]	28	97%

[1] *Six samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample is 29.*

CCHA Region 7: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for CCHA Region 7:

- CCHA Region 7 increased the number of timely NABDs sent to members by 11 percentage points compared to FY 2022–2023.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the SUD UM Over-Read Audits

HSAG found the following opportunities for improvement:

- One of the denials in CCHA Region 7's sample was EPSDT eligible; however, the documentation did not include any mention of EPSDT considerations.
- UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making denial determinations.
- Although it is best practice for facilities to begin discharge planning upon the member's admission, many cases demonstrated a delay in discharge planning, resulting in members being denied additional coverage without a stable discharge plan, which increased relapse risk.

To address these opportunities for improvement, HSAG recommends CCHA Region 7:

- Include specific documentation in the UM system notes to demonstrate the review of EPSDT criteria for eligible members.

- Provide training for providers and UM reviewers on the importance of considering interdimensional interactions and co-occurring problems in the review process.
- Provide additional training for providers regarding discharge planning as well as using care coordination and other available resources to provide assistance with discharge planning and continuity of care.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended that CCHA Region 7:

- Update policies, procedures, and processes to ensure that members and providers are notified about the denial decision in a timely manner.
- Develop and use an NABD template to ensure that member communications regarding adverse benefit determinations include a description of each ASAM dimension.

Assessment of CCHA Region 7's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

CCHA Region 7 reported addressing HSAG's recommendations by :

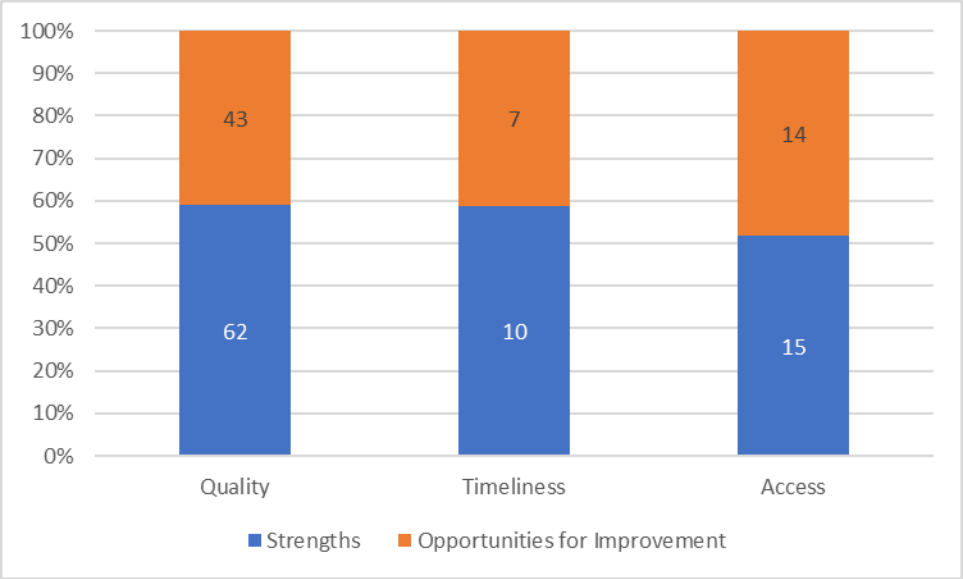
- Conducting monthly staff trainings regarding the NABD turnaround time frame.
- Ensuring monthly turnaround time reports are sent to all UM associates to monitor timeliness of the denial determination within the required time frame.
- Providing training with medical directors to include all six dimensions within the NABD.
- During audits, notifying medical directors of missing language to ensure compliance.
- Conducting monthly and/or quarterly collaboration meetings with high-volume SUD providers on ASAM trainings and resources on the CCHA website, Department resources, and resources directly from ASAM.
- Using the CCHA provider newsletter to communicate updates regarding the SUD benefit and resources for ASAM trainings.

HSAG anticipates CCHA Region 7's responses to the recommendations are likely to improve overall processes, communication with members, and compliance with State and federal regulations. CCHA Region 7 should continue addressing the recommendations made by HSAG for continuous improvement and staff development.

Managed Care Organizations

Denver Health Medical Plan

Figure 4-8—Number of Strengths and Opportunities for Improvement by Care Domain for DHMP*



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

The following are DHMP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment related to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

DHMP submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Improving Well-Care Visit [WCV] Rates for Child and Adolescent DHMP Medicaid Members* PIP and the nonclinical *Improving Social Determinants of Health [SDOH] Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. DHMP resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 4-122 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members*

Table 4-122—2023–2024 PIP Overall Confidence Levels for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	63%	*No Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **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)*.

[3] **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*.

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

The *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services*

Table 4-123—2023–2024 PIP Overall Confidence Levels for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	50%	*No Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members*

Table 4-124 displays data for DHMP's *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP.

Table 4-124—Performance Indicator Results for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of DHMP Medicaid members ages 3–21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.	N: 14,725 D: 34,017	43.29%					

N–Numerator D–Denominator

For the baseline measurement period, DHMP reported that 43.29 percent of MCO members ages 3 to 21 years had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services*

Table 4-125 displays data for DHMP's *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 4-125—Performance Indicator Results for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 7,390 D: 33,217	22.25%					

N–Numerator D–Denominator

For the baseline measurement period, DHMP reported that 22.25 percent of Medicaid members with at least one primary care visit at Denver Health were screened for SDOH during the measurement year.

Interventions

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members*

Table 4-126 displays the barriers and interventions documented by the health plan for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP.

Table 4-126—Barriers and Interventions for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP

Barriers	Interventions
• Lack of member awareness of the need for an annual well visit • Lack of transportation • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment • Lack of motivation to schedule and attend an annual well visit	Population Health outreach to members who are overdue for the annual well visit
• Lack of member awareness of the need for an annual well visit • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment	Automated reminder phone calls to members who are overdue for the annual well visit
Lack of motivation to schedule and attend an annual well visit	Member incentive for well visit completion

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services*

Table 4-6 displays the barriers and interventions documented by the health plan for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 4-127—Barriers and Interventions for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP

Barriers	Interventions
Medical assistant (MA) staff turnover	Reviewing clinic workflows with MA staff to ensure SDOH screening occurs during the visit

Barriers	Interventions
• MA staff turnover • Competing priorities at visits	MyChart SDOH pre-visit screening offers the member an opportunity to complete the SDOH screening prior to the visit

DHMP: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- DHMP reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

DHMP: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. DHMP addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and DHMP received *High Confidence* for the final Module 4 submission. DHMP's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

HEDIS/Core Set Measure Rates and Validation

DHMP: Information Systems Standards Review

According to the HEDIS MY 2023 FAR, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted DHMP's performance measure reporting.

DHMP: Performance Measure Results

Table 4-128 shows the performance measure results for DHMP for MY 2021 through MY 2023, along with the percentile ranking for each MY 2023 rate, if available. Rates for MY 2023 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2023 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Please note that this table presents performance measure rates reported using administrative methodology, while performance measure rates reported using hybrid methodology are presented in Appendix A.

Table 4-128—Performance Measure Results for DHMP

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
52 to 64 Years[H]	41.70%	46.91%	52.05%^	BTSA
65 to 74 Years[H]	30.96%	35.82%	40.18%^	WTSA
Cervical Cancer Screening				
Total[H]	39.36%	34.24%	40.81%^	<10th
Child and Adolescent Well-Care Visits				
Total[H]	41.93%	42.90%	46.56%^	25th–49th
Childhood Immunization Status				
Combination 3[H]	61.92%	72.47%	69.05%	75th–89th
Combination 7[H]	53.08%	59.64%	64.51%^	75th–89th
Combination 10[H]	40.22%	42.05%	44.33%	75th–89th
Chlamydia Screening in Women				
16 to 20 Years[H]	76.77%	77.04%	80.86%^	≥90th
21 to 24 Years[H]	68.54%	70.33%	70.89%	≥90th
Colorectal Cancer Screening				
46 to 50 Years[H]	NA	14.01%	16.99%	WTSA
51 to 65 Years[H]	NA	27.05%	29.30%	WTSA
66 Years and Older[H]	NA	32.99%	33.45%	WTSA

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Developmental Screening in the First Three Years of Life				
Total[SA]	NA	60.80%	68.63%^	BTSA
Immunizations for Adolescents				
Combination 1[H]	64.92%	71.77%	**63.07%^^**	<10th
Combination 2[H]	35.93%	36.84%	38.97%	50th–74th
Lead Screening in Children				
Total[H]	NA	61.16%	59.10%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total[H]	70.33%	68.09%	67.28%	10th–24th
Counseling for Nutrition—Total[H]	74.36%	73.10%	75.55%	50th–74th
Counseling for Physical Activity—Total[H]	73.75%	71.96%	74.79%	50th–74th
Well Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	54.34%	58.28%	58.62%	50th–74th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	54.42%	59.29%	64.19%^	25th–49th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years[SA]	NA	20.68%	21.30%	WTSA
MMEC—21 to 44 Years[SA]	NA	18.89%	19.29%	WTSA
LARC—15 to 20 Years[SA]	NA	5.30%	5.81%	WTSA
LARC—21 to 44 Years[SA]	NA	4.95%	4.93%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days[SA]	NA	25.68%	29.79%	BTSA
MMEC—21 to 44 Years—3 Days[SA]	NA	27.59%	25.94%	BTSA
MMEC—15 to 20 Years—90 Days[SA]	NA	59.46%	65.96%	BTSA
MMEC—21 to 44 Years—90 Day[SA]	NA	56.40%	54.23%	BTSA
LARC—15 to 20 Years—3 Day[SA]	NA	6.76%	13.83%	BTSA
LARC—21 to 44 Years—3 Days[SA]	NA	10.21%	8.74%	BTSA
LARC—15 to 20 Years—90 Day[SA]	NA	27.03%	34.04%	BTSA
LARC—21 to 44 Years—90 Days[SA]	NA	25.91%	25.52%	BTSA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—21 Years and Older[H]	NA	NA	83.86%	BTSA
Postpartum Care—21 Years and Older[H]	NA	NA	78.52%	BTSA
Timeliness of Prenatal Care—Under 21 Years[H]	NA	NA	80.41%	BTSA
Postpartum Care—Under 21 Years[H]	NA	NA	79.05%	BTSA

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years[H]	59.89%	58.05%	68.24%	WTSA
19 to 64 Years[H]	47.38%	51.91%	53.68%	WTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years[H]	97.50%	96.52%	95.16%	≥90th
18 to 64 Years[H]	57.53%	68.26%	72.69%	≥90th
65 Years and Older[H]	NA	NA	NA	—
Concurrent Use of Opioids and Benzodiazepines				
*18 to 64 Years**[,SA]	NA	5.74%	5.46%	BTSA
*65 Years and Older**[,SA]	NA	6.52%	5.88%	BTSA
Controlling High Blood Pressure				
18 to 64 Years[H]	48.54%	47.93%	51.61%^	BTSA
65 to 85 Years[H]	55.92%	56.64%	58.19%	BTSA
HbA1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18 to 64 Years	NA	44.94%	48.64%^	BTSA
HbA1c Control (<8.0%)—65 to 75 Years	NA	51.44%	54.73%	BTSA
*HbA1c Poor Control (>9.0%)—18 to 64 Years**[,H]	47.92%	45.15%	41.99%^	BTSA
*HbA1c Poor Control (>9.0%)—65 to 75 Years**[,H]	35.28%	37.77%	36.66%	BTSA
HIV Viral Load Suppression				
18 to 64 Years[SA]	NA	NA	68.19%	BTSA
65 Years and Older[SA]	NA	NA	80.00%	BTSA
Use of Opioids at High Dosage in Persons Without Cancer				
*18 to 64 Years**[,SA]	NA	5.04%	4.64%	WTSA
*65 Years and Older**[,SA]	NA	4.88%	5.83%	WTSA
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	47.54%	47.15%	52.97%	10th–24th
Antidepressant Medication Management				
Effective Acute Phase Treatment—18 to 64 Years[H]	64.50%	66.37%	66.19%	WTSA
Effective Acute Phase Treatment—65 Years and Older[H]	78.00%	76.92%	81.08%	WTSA
Effective Continuation Phase Treatment—18 to 64 Years[H]	42.55%	46.53%	42.60%	WTSA
Effective Continuation Phase Treatment—65 Years and Older[H]	72.00%	53.85%	48.65%	BTSA
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)				
18 to 64 Years[*,H]	NA	53.93%	45.06%	BTSA
65 to 75 Years[*,H]	NA	NA	NA	—

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[H]	86.68%	85.52%	88.59%	≥90th
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years[H]	15.71%	9.30%	12.09%	<10th
7-Day Follow-Up—18 to 64 Years[H]	21.44%	16.74%	17.16%	<10th
7-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years[H]	31.43%	25.58%	30.77%	<10th
30-Day Follow-Up—18 to 64 Years[H]	29.02%	24.17%	27.70%	<10th
30-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years[H]	9.30%	17.65%	**4.44%^^**	BTSA
7-Day Follow-Up—18 to 64 Years[H]	15.29%	20.78%	18.13%	WTSA
7-Day Follow-Up—65 Years and Older[H]	2.08%	14.89%	11.86%	WTSA
30-Day Follow-Up—13 to 17 Years[H]	9.30%	23.53%	11.11%	BTSA
30-Day Follow-Up—18 to 64 Years[H]	21.09%	28.33%	28.17%	WTSA
30-Day Follow-Up—65 Years and Older[H]	6.25%	21.28%	20.34%	WTSA
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]	8.54%	2.47%	11.36%^	<10th
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]	15.85%	17.28%	20.45%	<10th
30-Day Follow-Up—65 Years and Older[H]	8.54%	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	30.95%	38.89%	42.02%	25th–49th
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—18 to 64 Years[H]	42.20%	41.59%	41.81%	BTSA
Initiation of SUD Treatment—Total—65 Years and Older[H]	61.38%	58.24%	47.56%	BTSA
Engagement of SUD Treatment—Total—18 to 64 Years[H]	6.40%	7.07%	7.21%	WTSA
Engagement of SUD Treatment—Total—65 Years and Older[H]	6.90%	4.71%	3.66%	BTSA
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[H]	NA	NA	77.14%	≥90th
Cholesterol Testing—Total[H]	NA	NA	54.29%	≥90th
Blood Glucose and Cholesterol Testing—Total[H]	NA	NA	54.29%	≥90th

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Screening for Depression and Follow-Up Plan				
12 to 17 Years[SA]	NA	34.14%	32.25%	BTSA
18 to 64 Years[SA]	NA	18.40%	21.28%	BTSA
65 Years and Older[SA]	NA	6.26%	6.98%	BTSA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total[H]	NA	NA	NA	—
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	NA	51.62%	**38.92%^^**	WTSA
Rate 2: Buprenorphine[SA]	NA	48.70%	**33.84%^^**	WTSA
Rate 3: Oral Naltrexone[SA]	NA	1.95%	3.66%	BTSA
Rate 4: Long-Acting, Injectable Naltrexone[SA]	NA	1.62%	1.32%	BTSA
Rate 5: Methadone[SA]	NA	0.32%	1.63%	WTSA
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years [*,SA]	22.47	26.43	25.89	—
Plan All-Cause Readmissions				
Observed Rate[H]	NA	9.54%	10.24%	—
Expected Rate[H]	NA	9.49%	9.69%	—
O/E Ratio[*,H]	NA	1.0051	1.0567	<10th
PQI 01: Diabetes Short-Term Complications Admission Rate				
18 to 64 Years[*,SA]	NA	16.69	15.48	—
65 Years and Older[*,SA]	NA	0.00	5.57	—
PQI 05: COPD or Asthma in Older Adults Admission Rate				
40 to 64 Years[*,SA]	NA	20.13	17.43	—
65 Years and Older[*,SA]	NA	43.95	38.97	—
PQI 08: Heart Failure Admission Rate				
18 to 64 Years[*,SA]	NA	24.10	25.61	—
65 Years and Older[*,SA]	NA	1,385.48	952.38	—
PQI 15: Asthma in Younger Adults Admission Rate				
18 to 39 Years[*,SA]	NA	3.50	2.82	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

DHMP: Strengths

The following required HEDIS MY 2023 measure rates were determined to be high-performing rates for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2022, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2022):

- *Childhood Immunization Status—Combination 3, Combination 7, Combination 10*
- *Chlamydia Screening in Women—16 to 20 Years* and *21 to 24 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months to 17 Years* and *18 to 64 Years*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

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

The following required HEDIS MY 2023 measure rates were determined to be low-performing rates for DHMP (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from MY 2022):

- *Cervical Cancer Screening*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6 to 17 Years* and *18 to 64 Years*, and *30-Day Follow-Up—6 to 17 Years* and *18 to 64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18 to 64 Years* and *30-Day Follow-Up—18 to 64 Years*

To address these low measure rates, HSAG recommends DHMP:

- For the *Cervical Cancer Screening* measure, consider utilizing Community Health Workers (CHWs) or another one-on-one interaction with a healthcare professional, as they have been shown to

improve cervical cancer screenings.[33] Health literacy campaigns might also be helpful, as well as focusing on barriers to completing screenings and addressing SDOH.[34]

- For the *Immunizations for Adolescents—Combination 1* indicator and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* indicator, HSAG recommends DHMP provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. HSAG recommends that DHMP create a provider report that indicates which members have care gaps in this area to help focus outreach for scheduling visits.
- For the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends DHMP consider a specialty care management program aimed at linking members with specialty providers who can offer intensive community-based mental health services such as case management, medication management and nurse services, and team-based care. DHMP can provide support to specialty mental health providers by providing specialty pharmacy services, transportation options, and provider incentive programs that reward team-based care models.
- For the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures, consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[35]

Follow-Up on FY 2022–2023 HEDIS/Core Set Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the MCOs consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

[33] Popalis ML, Ramirez SI, Leach KM, Granzow ME, Stoltzfus KC, Moss JL. Improving cervical cancer screening rates: a scoping review of resources and interventions. Cancer Causes Control. 2022 Nov;33(11):1325-1333. Available at: https://pubmed.ncbi.nlm.nih.gov/35980511/. Accessed on: Dec 13, 2024.

[34] Suk R, Hong Y, Rajan SS, Xie Z, Zhu Y, Spencer JC. Assessment of US Preventive Services Task Force Guideline–Concordant Cervical Cancer Screening Rates and Reasons for Underscreening by Age, Race and Ethnicity, Sexual Orientation, Rurality, and Insurance, 2005 to 2019. *JAMA Netw Open*. 2022;5(1):e2143582. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788175. Accessed on: Dec 13, 2024.

[35] Mao W, Shalaby R, Agyapong VIO. Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. *Healthcare*. 2023; 11(8):1161. Available at: https://www.mdpi.com/2227-9032/11/8/1161. Accessed on: Nov 21, 2024.

- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Assessment of DHMP's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- Multiple outreach campaigns, including EPSDT outreach conducted through IVR to identify members in need of screenings and services (three rounds of calls were conducted, averaging 13,000 calls a round); text message reminders three days before a well-child appointment for ages 3 and older to a guardian on file to remind them of their upcoming important well-child visit; and 24,889 mammogram reminder mailers to female members which included information on scheduling an appointment as well as a link to a calendar for the women's mobile clinic that allows members to schedule a mammogram at their home clinic and avoid travel to the Denver Health & Hospital Authority (DHHA) main campus.
- The expansion of an active partnership and collaboration in QI work group activities with DHHA Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, and annual visits. DHMP reported workgroups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated BH, transitions of care, SDOH, immunizations, and ambulatory care. Additionally, DHMP reported it partnered in a collaborative work process with the QI director of ACS and ACS QI staff members to build joint QI interventions, including shared data analytics.

HSAG recognizes that the member outreach campaigns and expanding QI workgroups are moderately likely to help improve and maintain performance rates. DHMP did not report specific campaigns, programs, or interventions geared toward pregnant members.

Assessment of Compliance With Medicaid Managed Care Regulations

DHMP Overall Evaluation

Table 4-129 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-129—Summary of DHMP Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	15	3	0	0	83%^
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%v
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%^
Totals	**54**	**54**	**47**	**7**	**0**	**0**	**87%**

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

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

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

DHMP: Trended Performance for Compliance With Regulations

Table 4-130 presents, for all standards, the overall percentage of compliance score for DHMP for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-130—Compliance With Regulations—Trended Performance for DHMP

Standard and Applicable Review Years	DHMP Average—Previous Review	DHMP Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	97%	97%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	87%	92%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	70%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	100%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**78%**	**83%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	83%	80%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**100%**	**94%**
Standard VIII—Credentialing and Recredentialing (2015–2016; 2020–2021)	98%	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**75%**	**25%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**94%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	86%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA**	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, DHMP demonstrated moderate to high-achieving scores for three out of four standards, two of which made improvements from the previous review cycle, demonstrating a general to strong understanding of most federal and State regulations. Ultimately, two standards, Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation, resulted in a decline from the previous review cycle.

DHMP: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP established a detailed process to notify members affected by a contracted provider termination at least 30 calendar days prior to the effective termination date or 15 days after the receipt of the termination notice.
- DHMP disseminated processes for detecting and preventing fraud, waste, and abuse, including the clear responsibilities of the CEO, board of directors, compliance committee, and chief compliance and audit officer.
- DHMP established processes to address data points around health equity, pediatric care, and maternal care.

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

HSAG found the following opportunities for improvement:

- Language in the provider termination notices was not easily understood and did not test at a sixth-grade reading level.
- The formulary drug list and welcome letter taglines were not in a conspicuously visible font size.
- The electronic provider directory located on the website did not include the direct URL to the provider website, whether the provider completed cultural competency training, and whether the provider has accommodations for people with disabilities.
- DHMP's policy and provider manual did not include "suspended" from participation in federal programs as a reason for not working with an entity.
- Written delegate agreements did not include all required language.

To address these opportunities for improvement, HSAG recommends DHMP:

- Review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.
- Revise the taglines in the formulary drug list and the welcome letter to be in a conspicuously visible font size.
- Make corrections to the provider directory to include: the direct URL to the provider website; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.

- Include "suspended" from participation in federal programs in its policy and provider manual.
- Update subcontractor agreements to include specific delegated activities, reporting responsibilities, and federal required language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- Update its NABD template to revise new requests to indicate the date that the determination was made, or for a concurrent review, the date that the concurrent authorization expires. Additionally, develop a process to ensure that the updated NABD is used consistently.
- Make changes to its Medicaid member handbook to include BH appointment timeliness standards and its Network Plan to include the 24-hour urgent care timeliness requirement.
- Ensure that timely written acknowledgement letters for appeals are sent.
- Modify its website to inform the members and the member representatives that this information must be provided upon request, free of charge, and sufficiently in advance of the appeal resolution time frame.
- Update its Medicaid appeal acknowledgement and resolution templates to state that both the State fair hearing and continuation of benefits must be requested within 10 days of receipt of the appeal resolution letter not in the member's favor.
- Update the "Continuation of Benefits" section of its website and the provider manual to state that DHMP will provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.
- Revise its provider manual to reflect accurate time frames of decisions on an expedited appeal, the time frame to file a State fair hearing, time frames of an appeal request, time frames of a continuation of benefits request, and clarify that the end of the service authorization expiration only impacts continuation of benefits when requesting an appeal but not during the State fair hearing.

Assessment of DHMP's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, DHMP updated the NABD template and developed a process to ensure updated NABD templates are used consistently. DHMP updated the Medicaid member handbook to include BH appointment timeliness standards. Timeliness of written acknowledgement letters for appeals were monitored by auditing cases to determine the acknowledgements were sent in a timely manner. Lastly, DHMP revised documents to reflect accurate time frames. HSAG recognizes that updating templates, the provider manual, and the member handbook, and monitoring the timeliness of appeal acknowledgement letters, is likely to result in long-term improvements.

Validation of Network Adequacy

DHMP: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP performed well in the BH network category, meeting all minimum network requirements for General Behavioral Health, Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.
- DHMP met minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS), Pediatric Primary Care Practitioner (MD, DO, NP, CNS), and Family Practitioner (MD, DO, NP, CNS) in 75 percent of contracted counties. Where DHMP did not meet the minimum network requirement for the specified provider categories, access was greater than 99.9 percent.
- While DHMP did not meet the minimum network requirements for a number of standards across all contracted counties, the rate of access for provider types including Adult, Pediatric, and Family Primary Care Practitioner (MD, DO, NP, CNS, and PA), Acute Care Hospitals, and an array of general and pediatric specialty providers was consistently 99 percent or greater.
- DHMP efficiently maintained the accuracy and completeness of provider information through its quarterly directory audit process. During each quarter, it evaluated a 20 percent sample of the provider directory. By year-end, it had thoroughly reviewed the entire directory.

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

HSAG found the following opportunities for improvement:

- DHMP did not meet the minimum network requirements for SUD Treatment Facilities across all ASAM LOCs in all contracted counties. DHMP struggled particularly with ASAM 3.2 WM, 3.3, and 3.7, with rates of access ranging from 0 percent to 0.2 percent in all contracted counties.

To address these opportunities for improvement, HSAG recommends DHMP:

- Conduct an in-depth review of provider categories for which DHMP did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that DHMP continue to conduct an in-depth review of provider categories for which COA did not meet the time-distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that DHMP:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, DHMP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure DHMP's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.
- DHMP utilized the COA directory for BH providers contracted with its Medicaid MCO LOB, but not for its CHP+ MCO LOB. MCEs with different names that share online provider directories could cause confusion or belief that a member is not utilizing the correct online provider directory. As such, DHMP could consider using its own provider directory for all LOBs.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of DHMP's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Expanded the PH network by contracting with various specialty and PCP providers to increase options for members and opportunities for collaboration with new providers. These providers included vision providers, non-Denver Public Schools school-based health centers, and BH and SUD providers for CHP+.
- Reviewed provider data collection processes for opportunities to improve information communicated in the provider directory
- Contracted with COA to facilitate BH services. DHMP reported that the inability to meet indicated time and distance standards is due to the taxonomy codes for SUD treatment facilities (particularly ASAM LOC 3.1 and above) not tracking to the correct category. DHMP described that COA obtains taxonomy code information from the Department MCO report based on how providers fill

out their information for the Department's provider validation. However, these taxonomy codes do not always align with a provider's NPI provider type and may not be validated at the location level.

Based on the above response, DHMP worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—DHMP 411 Over-Read

Table 4-131 presents DHMP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-131—FY 2023–2024 Self-Reported EDV Results by Data Element and BH Service Category for DHMP

Data Element	Inpatient Services (137 Cases)	Psychotherapy Services (137 Cases)	Residential Services (137 Cases)
Procedure Code	NA	88.3%	97.8%
Diagnosis Code	91.2%	93.4%	94.9%
Place of Service	NA	74.5%	97.8%
Service Category Modifier	NA	88.3%	97.8%
Units	NA	96.4%	97.8%
Revenue Code	72.3%	NA	NA
Discharge Status	94.2%	NA	NA
Service Start Date	93.4%	96.4%	97.8%
Service End Date	46.7%	96.4%	97.8%
Population	NA	96.4%	97.8%
Duration	NA	94.9%	97.8%
Staff Requirement	NA	87.6%	93.4%

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

Table 4-132 presents, by BH service category, the number and percentage of cases in which HSAG's over-read results agreed with DHMP's EDV results for each of the validated data elements.

Table 4-132—FY 2023–2024 BH EDV Over-Read Agreement Results by BH Service Category for DHMP

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

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

DHMP: Strengths

Based on 411 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

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

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to DHMP's 411 Audit Over-Read

HSAG found the following opportunities for improvement:

- While the over-read results suggest confidence in DHMP's EDV results, DHMP's self-reported EDV results for inpatient services and psychotherapy services demonstrated a moderate level of encounter data accuracy. For inpatient services, DHMP self-reported a 46.7 percent accuracy rate for the *Service End Date* data element and a 72.3 percent accuracy rate for the *Revenue Code* data element when compared to the corresponding medical record. For psychotherapy services, DHMP self-reported a 74.5 percent accuracy rate for the *Place of Service* data element when compared to the corresponding medical records.

To address these opportunities for improvement, HSAG recommends DHMP:

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

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended DHMP consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Assessment of DHMP's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

DHMP reported implementing CAPs for providers with a sufficient number of records that scored below a 95 percent in the DHMP 411 over-read. The CAPs included a root cause analysis, retraining staff, enhancing systems, and provider re-audits. DHMP also reported offering provider education and training on quality documentation.

Based on DHMP's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve BH service coding accuracy.

Encounter Data Validation—DHMP 412 Over-Read

Table 4-133 presents DHMP's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 4-133—FY 2023–2024 Self-Reported EDV Results by Data Element and Service Category for DHMP

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	99.0%	99.0%	89.3%	100%
Through Date	98.1%	NA	NA	NA
Diagnosis Code	89.3%	90.3%	71.8%	63.1%
Surgical Procedure Code	98.1%	NA	NA	NA
Procedure Code	NA	96.1%	69.9%	91.3%
Procedure Code Modifier	NA	100%	90.3%	92.2%
Discharge Status	93.2%	NA	NA	NA
Units	NA	96.1%	93.2%	98.1%

NA indicates that a data element was not evaluated for the specified service category.
Percentages in this table reflect DHMP's most recent self-reported EDV results.

Table 4-134 presents DHMP's FY 2023–2024 EDV over-read case-level and element-level accuracy rates by service category.

Table 4-134—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for DHMP

	Case-Level Accuracy		Element-Level Accuracy	
Service Category	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	95.0%	120	99.2%
Outpatient	20	100%	100	100%
Professional	20	100%	100	100%
FQHC	20	100%	100	100%
Total	**80**	**98.8%**	**420**	**99.8%**

DHMP: Strengths

Based on MCO 412 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- HSAG agreed with 99.8 percent of DHMP's internal validation results for the total number of individual data elements reviewed. This number is higher than the 97.9 percent agreement rate reported in FY 2022–2023.
- HSAG's over-read results suggest a high level of confidence that DHMP's independent validation findings accurately reflect the encounter data quality summarized in the self-reported service coding accuracy results.
- The self-reported service coding accuracy results showed that all five key data elements for the outpatient cases had accuracy rates greater than 90 percent.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to MCO 412 Audit Over-Read

HSAG found the following opportunities for improvement:

- The accuracy rate for the *Diagnosis Code* data element was only 71.8 percent among the professional encounters in the self-reported service coding accuracy report.
- The varying service coding accuracy rates show that the service coding accuracy is not consistent within the four service categories.

To address these opportunities for improvement, HSAG recommends DHMP:

- Consider internal data monitoring and provider training to improve medical record documentation.

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended that DHMP consider internal data monitoring and provider training to improve medical record documentation.

Assessment of DHMP's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

DHMP reported implementing the following approaches to address encounter data recommendations:

- DHMP reported that letters were sent to project partners alerting them to the errors identified in the respective claims. The letter was sent to the compliance teams for the project partners and informed

them of the forthcoming intervention sampling and provided an opportunity for questions and education.

- DHMP reported that claims identified with repeated errors during the intervention sampling were reprocessed and denied, requiring the project partner to review the medical records and correct the claims and resubmit them for reimbursement.

Based on DHMP's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve encounter data accuracy.

CAHPS Survey

DHMP: Adult CAHPS

Table 4-135 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2021–2022 through FY 2023–2024.

Table 4-135—Adult CAHPS Results for DHMP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	58.55%	58.93%	56.58%
Rating of All Health Care	52.85%	51.06%	51.74%
Rating of Personal Doctor	68.95%	68.24%	73.10%
Rating of Specialist Seen Most Often	70.64%	62.00%	63.11%
Getting Needed Care	71.73%	72.01%	75.18% ↓
Getting Care Quickly	71.30%	71.29%	71.48% ↓
How Well Doctors Communicate	92.10%	91.68%	93.54%
Customer Service	87.86%	88.88%+	90.20%
Coordination of Care	81.90%	86.05%+	90.20%
Advising Smokers and Tobacco Users to Quit	66.88%	65.89%	68.12%
Discussing Cessation Medications	51.97%	55.81%	58.09%
Discussing Cessation Strategies	49.01%	48.44%	49.63%

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

DHMP: Strengths

The following measures' FY 2023–2024 scores for DHMP were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *Rating of Personal Doctor*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*
- *Discussing Cessation Medications*
- *Discussion Cessation Strategies*

The following measures' FY 2023–2024 scores for DHMP were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

The following measures' FY 2023–2024 scores for DHMP were statistically significantly lower than the 2023 NCQA national averages:

- *Getting Needed Care*

- *Getting Care Quickly*

The following measure's FY 2023–2024 score for DHMP was lower, although not statistically significantly, than the FY 2022–2023 score:

- *Rating of Health Plan*

To address these low CAHPS scores, HSAG recommends DHMP consider:

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.
- Exploring any barriers to receiving timely care from providers that may result in lower levels of experience.
- Obtaining and analyzing members' experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctors' offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Exploring ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

DHMP: General Child CAHPS[36]

Table 4-136 shows the general child Medicaid CAHPS results achieved by DHMP for FY 2021–2022 through FY 2023–2024.

Table 4-136—General Child CAHPS Results for DHMP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	72.28%	73.14%	73.89%
Rating of All Health Care	70.65%+	72.41%+	76.42% ↑
Rating of Personal Doctor	82.26%	84.55%	84.40% ↑
Rating of Specialist Seen Most Often	87.50%+	65.00%+	71.79%+
Getting Needed Care	80.22%+	71.37%+	74.46%+
Getting Care Quickly	82.09%+	78.08%+	79.22%+

[36] Since this is the first year the CAHPS Survey with the CCC measurement set was administered to parents/caretakers of child RAE members in the State of Colorado, trend results were not performed for the RAE or MCO CCC population.

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
How Well Doctors Communicate	93.67%+	93.95%+	92.01%+
Customer Service	89.59%+	88.89%+	84.17%+
Coordination of Care	91.18%+	80.00%+	73.17%+

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 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

DHMP: Strengths

The following measures' FY 2023–2024 scores for DHMP were statistically significantly higher than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for DHMP were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measures' FY 2023–2024 scores for DHMP were lower, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for DHMP were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends DHMP consider:

- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of child members experiences, adherence to treatments, and management of their child's conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of child members perspectives. Physicians could ask questions about the parents'/caretakers' of child members concerns, priorities, and values and listen to their answers.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker of the child member, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Exploring ways to direct parents/caretakers of child members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, DHMP reported engaging in the following QI initiatives:

- A member experience committee, which met monthly to discuss all CAHPS categories and issues contributing to barriers across all LOBs, was implemented.
- DHMP collaborated with Square ML, a machine learning vendor, to develop a comprehensive CAHPS dashboard. The initiative included automating processes to minimize the resources required for manual data manipulation and employing AI technology to extract and categorize trends from member survey feedback. Upon development, DHMP will implement this solution across all LOBs.
- Its website was enhanced by adding a dedicated space where members could inquire about claims and submit appeals, which ensured a more streamlined and efficient experience for members.
- Access to care was added as a key performance indicator to DHMP's strategic plan for the upcoming three years. Additionally, the DHHA Access to Care Committee was tasked with enhancing access to care. DHMP regularly communicated with the committee, provided weekly lists of members who were waitlisted and unable to secure timely visits, addressed those issues, and implemented necessary adjustments to appointment availability.
- High-level education regarding health plan CAHPS scores was provided to clinics.
- To increase member outreach through Ambulatory Care Services (ACS) care support initiatives, DHMP focused on addressing gaps in care and promoting preventive health screenings. Over the last year, DHMP's care management team conducted outreach for well-child visits and maternity/postpartum care, successfully reaching 500 members. DHMP scheduled appointments for 196 members. Additionally, DHMP implemented three rounds of automated calls, averaging 13,000 members contacted in each round. Those efforts were complemented by follow-up communications for medication adherence and chronic condition management, significantly enhancing its member engagement and support.
- DHMP implemented focused member outreach by having the DHMP care management team facilitate care transitions based on acuity of need. DHMP's ADT feed, which will allow care managers to target members who are at high risk for readmissions and have preventable admissions, is being beta tested.
- Dental, family planning, and OB/GYN appointment types were added for scheduling via MyChart.
- Extended hours on weeknights and Saturday appointments were offered at multiple clinics.
- The DHMP member resources section of the DHMP website was revamped. The new version made it easier for members to find important information about plan benefits, preventive care, access to care, care and follow-up of important chronic conditions, and help with basic needs (e.g., food, utilities).

Assessment of DHMP's Approach to Addressing FY 2022–2023 CAHPS Recommendations

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

411 QUIP

Table 4-137 presents DHMP's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-137—Summary of DHMP 411 QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Diagnosis Code	89%	100%	90%	100%
Professional Services	Diagnosis Code	78%	80%	70%	50%
	Procedure Code	85%	80%	70%	50%
FQHC Services	Diagnosis Code	85%	100%	100%	100%
	Procedure Code	85%	100%	100%	100%

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

DHMP: Strengths

Based on 411 QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP reached 100 percent accuracy for month one for three out of five data elements and sustained 100 percent accuracy through month three.
- Key interventions for the QUIP consisted of issuing a CAP and providing education based on the specific topics that were identified.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the 411 QUIP

HSAG found the following opportunities for improvement:

- For the psychotherapy services category, DHMP reported low results for the *Place of Service* data element, which decreased throughout the QUIP due to provider signatures not being documented (or not being valid) in service documentation and supporting documentation not being provided at record submission.

To address these opportunities for improvement, HSAG recommends DHMP:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 411 QUIP Recommendations

FY 2022–2023 411 QUIP Recommendations

In FY 2022–2023, HSAG recommended that DHMP maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Assessment of DHMP's Approach to Addressing FY 2022–2023 411 QUIP Recommendations

DHMP reported that it implements CAPs for providers that score below 95 percent encounter accuracy in the 411EDV and requests enough records to assess general documentation practices. DHMP has responded to each component of HSAG's FY 2022–2023 411 QUIP recommendations. HSAG recognizes that the implementation of CAPs for providers that score below 95 percent encounter accuracy is likely to improve and maintain encounter data accuracy scores.

412 QUIP

Table 4-138 presents DHMP's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-138—Summary of DHMP 412 QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Inpatient Services	Diagnosis Code	89%	100%	90%	100%
Professional Services	Diagnosis Code	78%	80%	70%	50%
	Procedure Code	85%	80%	70%	50%
FQHC Services	Diagnosis Code	85%	100%	100%	100%
	Procedure Code	85%	100%	100%	100%

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

DHMP: Strengths

Based on 412 QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP's interventions resulted in an increase in accuracy ratings in four out of five data elements in month one. In month two, DHMP maintained accuracy for two data elements within the FQHC services; however, for the other two service categories, accuracy decreased for the three data elements.
- For FQHC services and inpatient services, DHMP increased the accuracy to 100 percent for three out of five data elements in month three, resulting in 100 percent accuracy.
- Key interventions for the three service categories addressed low outcomes by providing audit feedback letters to the providers that informed them of overall EDV results and the possibility of reprocessing claims if errors continued.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the 412 QUIP

HSAG found the following opportunities for improvement:

- DHMP reported that the pilot provider continued to experience issues with low accuracy results due to staff member error within the professional services service category. DHMP reported that further investigation and testing are needed to understand and address the decline in accuracy for the service category; therefore, it was not a sustainable intervention.
- DHMP reported that the need to explore coding resource development is a priority moving forward, but that there are budgetary limitations with this project.

To address these opportunities for improvement, HSAG recommends DHMP:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 412 QUIP Recommendations

FY 2022–2023 412 QUIP Recommendations

In FY 2022–2023, HSAG recommended that DHMP maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Assessment of DHMP's Approach to Addressing FY 2022–2023 412 QUIP Recommendations

DHMP reported it developed a letter and sent it to the providers alerting them to errors identified in the respective claims. DHMP sent the letter to the compliance teams for the providers and informed them of the forthcoming intervention sampling and provided an opportunity for questions and education. During the intervention, DHMP identified any claims with repeated errors, denied these claims, and required the provider to reprocess each claim after reviewing the medical record and correcting the claim. DHMP has responded to each component of HSAG's FY 2022–2023 412 QUIP recommendations. HSAG recognizes that notifying providers of errors and the requirement that the providers must resubmit corrected claims for reimbursement are most likely to improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-139 displays the MHP Audit compliance scores for DHMP for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-139—FY 2023–2024 MHP Audit Score for DHMP

MCO	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD and M/S Services				
DHMP	97%	Inpatient	94%	94%v
		Outpatient	95%	

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

DHMP: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP delegated BH and SUD UM to Colorado Access (COA). During the MHP interview, DHMP and COA staff members explained the bidirectional communication, ongoing collaboration, and regular standing meetings between the two entities.
- In all files except two, COA used nationally recognized UR criteria (InterQual for MH determinations or ASAM LOCs for SUD determinations).
- DHMP and COA required their UM staff members to pass IRR testing annually with a minimum score of 90 percent.
- In all 10 inpatient and 10 outpatient UR denial records and associated documents, all records except two demonstrated that COA followed DHMP's prior authorization list and UM policies and

procedures with regard to which services were subject to prior authorization requirements for processing requests for services.

- COA utilized *The ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice.
- COA made the denial determinations within the required time frame, and providers were notified of the denial determination through telephone or secure email and provided a copy of the NABD for all records reviewed.
- All records except one demonstrated that the member was sent the NABD within the required time frame.
- In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except one, the records contained evidence that a peer-to-peer review was offered to the requesting provider.
- All records demonstrated that the NABD reason for the denial was consistent with the reason documented in COA's UM system.
- All NABDs included the required content, such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing an appeal, access to pertinent records, and a brief reason for the denial. Additionally, COA consistently utilized the new revised NABD template language that explained DHMP's delegation to COA across most of the NABDs reviewed.

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

HSAG found the following opportunities for improvement:

- COA did not send the member a NABD within the required time frame in one record reviewed.
- One record review did not contain evidence that a peer-to-peer review was offered to the requesting provider.
- Two records reviewed did not demonstrate the use of established UR criteria (InterQual or ASAM).
- While the NABDs included the required content, such as the member's appeal rights and a brief reason explaining the denial, two inpatient SUD NABDs did not list the required ASAM dimensions and how they were considered when determining medical necessity.

To address these opportunities for improvement, HSAG recommends DHMP:

- Enhance monitoring mechanisms to ensure that the member is sent the NABD within the required time frame.

- Follow established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- Ensure all denial determinations due to medical necessity use established UR criteria (InterQual or ASAM) and staff members document and save criteria used in the UM system.
- Include each of the required ASAM dimensions in the inpatient SUD NABDs and conduct periodic chart audits to ensure consistency.
- As a best practice, include in the NABDs (other than the SUD NABDs, which mostly included the required ASAM dimensions) reference to COA's criteria (i.e., InterQual) used in making the determination and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- Enhance monitoring procedures to ensure that the member is sent the NABD within the required time frame.
- Periodically train staff members and conduct monthly record audits to ensure NABDs are at an easy-to-understand reading grade level and include the required language, such as the ASAM dimensions within inpatient and residential SUD NABDs. Additionally, ensure staff members who are assigned to DHMP authorizations use the correct revised template regarding DHMP's delegation to COA.
- As a best practice, other than the SUD NABDs, which ordinarily included the required ASAM dimensions, include reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and include more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Assessment of DHMP's Approach to Addressing FY 2022–2023 MHP Recommendations

DHMP reported addressing HSAG's recommendations by:

- Reviewing and optimizing COA UM internal processes to ensure timely communication of denial determinations and emphasizing the importance of adhering to time frames to ensure compliance during staff trainings.
- Conducting staff trainings and record audits for COA UM staff members. Additionally, DHMP reported providing DHMP UM staff trainings to reinforce knowledge of services that should be redirected to COA.
- Including more specific information regarding the member's condition that are meant to convey the criteria and reason for the denial determination and evaluating the NABD templates for improvement.

- Providing ongoing training for COA UM staff members to ensure staff members are proficient in applying InterQual and ASAM criteria consistently. Additionally, DHMP reported reviewing regular auditing metrics and procedures to confirm accurate analysis of team performance as it relates to denial determinations.
- Continuing biannual meetings and trainings with COA and DHMP UM staff to discuss UM practices, review letters, and discuss programmatic changes to ensure alignment.

DHMP still has the opportunity to address HSAG's recommendation of enhancing monitoring procedures to ensure that the member is sent the NABD within the required time frame, including each of the required ASAM dimensions within inpatient and residential SUD NABDs, and including the specific name of the criteria (i.e., InterQual) used to make the denial determination in the NABD. HSAG acknowledges that COA, on behalf of DHMP, pursued additional guidance from HSAG and the Department regarding NABD template updates to include InterQual language in a manner that is member friendly. DHMP's reported updates will most likely help DHMP demonstrate improvement to overall UM processes. DHMP should continue to address the recommendations made by HSAG and continue working with COA to ensure alignment with UM processes and help achieve MHP compliance.

QOC Grievances and Concerns Audit

In CY 2023, DHMP investigated eight potential QOCG cases. DHMP's average membership in CY 2023 was 101,840, with 85,020 members enrolled as of December 31, 2023. Of the eight QOCG cases investigated by DHMP and COA, four cases were substantiated.

DHMP: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found that while DHMP did not exceed minimum expectations, the submitted documents did describe its process for investigating, analyzing, tracking, trending, and resolving QOCGs when a PH concern is raised. COA's policies and procedures also described its process for investigating, analyzing, tracking, trending, and resolving QOCGs on DHMP's behalf if a BH concern was raised.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- DHMP's policy states that the originator of the QOCG will receive an acknowledgement letter within two days of receipt of the QOCG and that DHMP will resolve the QOCG within 15 days of receipt of the QOCG. DHMP did not send acknowledgement letters within the two-day period for two of the eight cases; therefore, DHMP did not meet the timeliness standard in its policy. COA did not close one case within the 15-day period, also not meeting the timeliness standard set by its policy.

- Documents submitted by DHMP did not specifically address how DHMP defines a "QOCC" or a "QOCG."
- The *DHMP Member Handbook* included information about the process for filing a grievance; however, the handbook did not distinguish between a member grievance and a QOCG.
- DHMP's *Quality of Care Complaints Job Aid* included the categories of findings (*Unsubstantiated*, *Substantiated*, and *Inconclusive*), but DHMP did not use a severity rating scale. Although the job aid included the categories, it did not include definitions for each determination nor address potential actions based on the finding categories.
- The submitted documents did not specifically address how DHMP is to follow up with the member to determine if the member's immediate healthcare needs are being met.
- The submitted documents did not address when DHMP is to notify the Department regarding a QOCG or submit a QOC summary as outlined in the MCE contract.

To address these opportunities, HSAG recommends that DHMP:

- Work with its delegate, COA, to ensure adherence to all policies and procedures.
- Update applicable documents to specifically define "QOCC" and "QOCG."
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Develop and update applicable documents and job aids to include the finding category definitions and provide potential actions based on the finding categories.
- Update its applicable policies and procedures to address how DHMP is to follow up with the member to determine if the member's immediate healthcare needs are being met.
- Implement a process for notifying the Department that a QOCG has been received and document the process for submitting a QOC summary to ensure compliance with the MCE contract.

Follow-Up on FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023; however, DHMP reported ongoing QI efforts to address the FY 2021–2022 recommendations.

Review and Assessment of DHMP's Approach to Addressing FY 2021–2022 QOC Grievances and Concerns Audit Recommendations

DHMP reported addressing HSAG's recommendations by:

- Reviewing policies and processes to ensure potential QOCGs are captured at all possible avenues (e.g., members, providers, MRR).

DHMP still has the opportunity to update policies, procedures, and processes to ensure the delegation of BH QOC complaints to COA and to notify the Department of QOCGs received. DHMP should continue to address the recommendations made by HSAG to improve the process of addressing QOCGs from all referral sources.

EPSDT Audit

Table 4-140 displays the findings derived from the following audit activities conducted in FY 2023–2024: desk review of policies and procedures, review of records for members who had not utilized services for a period of at least one year, and a review of records for members who had been denied a service within the review period of FY 2022–2023.

Table 4-140—FY 2023–2024 EPSDT Audit Findings for DHMP

Topic	Policy and Procedure Review	Evidence of Implementation	Total Score
Desk Review Findings	100%	83%	92%
Non-Utilizer Record Review	100%	25%	63%
Post-Denial Record Review	92%	50%	71%

DHMP: Strengths

Based on EPSDT Audit activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- Most cases reviewed demonstrated the member was already involved in care coordination.
- DHMP outreached any new members by phone if the member had not completed the written health needs assessment (HNA) within 10 days of the mailing, which was recognized as a best practice for additional efforts in obtaining a completed HNA.
- 14 of the 15 sample cases reviewed included evidence that the Healthy Hero mailer (a postcard) was sent within the first week of the month of the member's birthday during the review period.

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

HSAG found the following opportunities for improvement:

- All 15 medical necessity denials reviewed demonstrated that UM staff members utilized InterQual criteria, which do not explicitly consider EPSDT within the review process.

- DHMP staff reported a noticeable increase in request for psychological or neuro-psychological diagnostic testing, and all six of the denials reviewed for this service came from the same provider.
- None of the NABDs for the denial records reviewed included the clinical criteria used to make the determination.
- The denial records reviewed included multiple samples that were denied due to a noncovered diagnosis. The records showed that the care coordinator worked with either the provider who requested the service or the member's family to help obtain the services. However, this was a different process than outlined in policies and procedures, which stated that providers are responsible for making referrals to another provider or to the UM case managers to assist with the referral.
- DHMP staff members reported that DHMP does not track returned mail to determine if the outreach was successful.
- The Healthy Hero mailer encouraged members to schedule a well-child exam and other services available to the member, but did not specifically target the member's situation related to not using particular services such as well visits, immunizations, dental services, or screenings.

To address these opportunities for improvement, HSAG recommends DHMP:

- Enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to the use of InterQual or ASAM, prior to issuing a denial.
- Identify providers receiving an above average amount of denials for services and provide ongoing training, education, and monitoring.
- Update its NABDs to include UM criteria utilized to be in compliance with the CFR, CCR, and the Department's NABD template.
- Clarify requirements for obtaining neuro-psychological testing for both covered and noncovered diagnoses.
- Consider assessing the amount of returned mail it receives if mailing is the sole outreach method for annual/non-utilizer outreach and consider using a different outreach modality in addition to the mailer.
- Target non-utilizer outreach to better help members understand which services are being recommended.

During the FY 2023–2024 EPSDT Audit, HSAG identified the following opportunities for improvement; however, these findings did not lead to recommendations:

- DHMP's materials included MyChart emails as an outreach method; this method required a member to sign up to receive the emails or a care manager to help sign the member up and for the member to opt in, which is likely not an effective mechanism for the non-utilizer population.
- DHMP's quarterly non-utilizer outreach reports demonstrated that DHMP interpreted the reporting template for follow-up interactions to not be for only non-utilizer members but all EPSDT eligible members.

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

Follow-Up on FY 2022–2023 EPSDT Recommendations

FY 2022–2023 EPSDT Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- Consider assessing the amount of returned mail DHMP receives if mailing is the sole outreach method.
- Target non-utilizer outreach to help members understand which services are being recommended.
- Consider adding the EPSDT flyer to applicable member letters, so members are aware of the program and eligibility.
- Further detail in its procedures how DHMP will participate in warm transfers to help members and family members engage with other agencies, as appropriate.

Assessment of DHMP's Approach to Addressing FY 2022–2023 EPSDT Recommendations

DHMP reported addressing HSAG's recommendations by:

- Sending annual birthday cards to children ages 2 through 19 that provided information about healthy eating, development, vaccines, physical history, and how to schedule a well-child appointment. The birthday cards serve as a reminder for well-child visits and education.
- Reviewing policies and NABD letters for consistency and connecting members to care management for support with noncovered services and services denied by UM.
- Including EPSDT-specific flyers with the HNA mailings.
- Adding immunizations and dental services tracked by DHMP's system, available by clinic and provider.

- Continuing to send reminder text messages three days before a well-child appointment to the parent/guardian on file. Additionally, sending important paperwork through MyChart for families to review and fill-out ahead of time to facilitate a smoother check-in process at the appointment and promote better information sharing.
- Providing a variety of services through the school-based health centers (SBHCs) for members and continuing to encourage members to access care through the network of SBHCs for their clinic needs. DHMP reported that members are now able to directly schedule appointments at their SBHC through their MyChart account.

DHMP still has the opportunity to address HSAG's recommendation of assessing the amount of mail returned that DHMP receives if using mail for outreach and targeting non-utilizer outreach to help members understand which services are being recommended. DHMP's reported updates will likely demonstrate improvement to member outreach efforts. DHMP should continue to address HSAG's recommendation to improve member communication, awareness, and EPSDT compliance.

Substance Use Disorder Utilization Management Over-Read

Table 4-141 displays the percentage of cases reviewed that HSAG's reviewers determined adhered to ASAM criteria.

Table 4-141—DHMP Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
DHMP	13	12[1]	11	92%

[1] *One sample was an administrative denial and was not applicable for medical necessity review; therefore, the total medical necessity sample is 12.*

Table 4-142 presents the number of cases in the sample that HSAG reviewed for DHMP and the percentage of cases in which HSAG's reviewers agreed with DHMP's denial determination.

Table 4-142—DHMP Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
DHMP	13	12[1]	11	92%

[1] *One sample was an administrative denial and was not applicable for medical necessity review; therefore, the total medical necessity sample is 12.*

DHMP: Strengths

Based on SUD UM Over-Read Audit activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP demonstrated improvement from the previous review period regarding the timeliness of NABDs sent to members.
- HSAG's reviewers agreed with the application of ASAM criteria in 92 percent of sample cases.
- HSAG's reviewers agreed with the denial determinations in 92 percent of sample cases.

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

HSAG found the following opportunities for improvement:

- DHMP did not provide an NABD to the member regarding the denial determination within the one administrative case reviewed.

To address these opportunities for improvement, HSAG recommends DHMP:

- Enhance monitoring mechanisms to ensure adherence for notifying the member of the administrative or medical necessity denial determination.

Follow-Up on FY 2022–2023 SUD UM Over-Read Recommendations

FY 2022–2023 SUD UM Over-Read Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- Update policies, procedures, and processes to ensure that members receive an NABD and within the required time frame.

Assessment of DHMP's Approach to Addressing FY 2022–2023 SUD UM Over-Read Recommendations

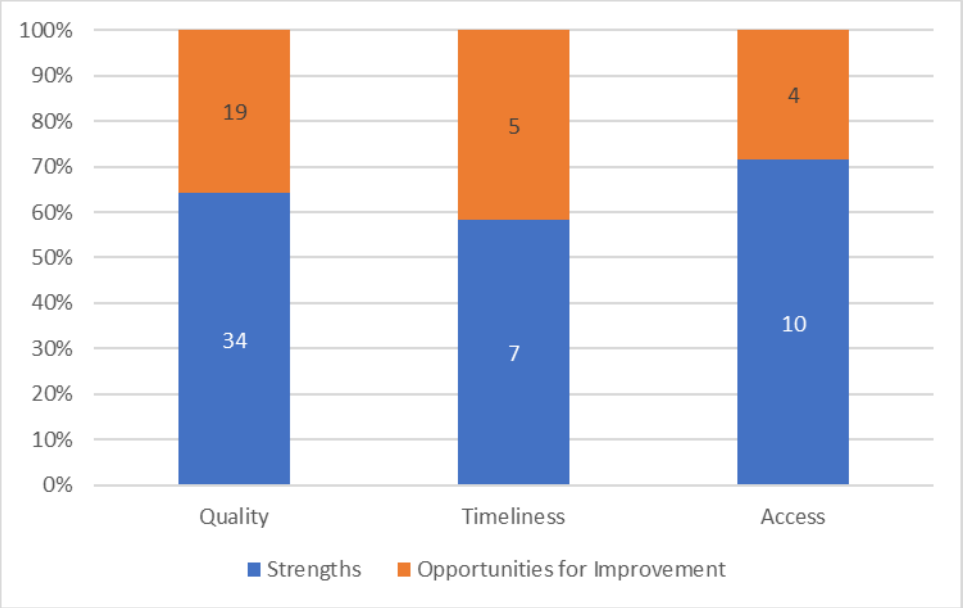
DHMP reported addressing HSAG's recommendations by:

- DHMP's UM delegate, COA, reported updating its UM auditing procedures to include evaluating NABDs for acronym usage and will continue to direct staff to write out the full meaning for each instance.

DHMP still has the opportunity to update policies, procedures, and processes to ensure that members receive an NABD and within the required time frame. DHMP should continue to address the recommendations made by HSAG to improve the process of making SUD UM determinations and communicating appropriately with its members.

Rocky Mountain Health Plans Medicaid Prime

Figure 4-9—Number of Strengths and Opportunities for Improvement by Care Domain for RMHP Prime*



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

The following are RMHP Prime's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment related to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

RMHP Prime submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Diabetes A1c Poor Control for Prime MCE [Managed Care Entity] Members* PIP and the nonclinical *Improving the Rate of SDOH [Social Determinants of Health] Screening for Prime Members* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. RMHP Prime resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 4-143 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *Diabetes A1c Poor Control for Prime MCE Members*

Table 4-143—2023–2024 PIP Overall Confidence Levels for the *Diabetes A1c Poor Control for Prime MCE Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
Resubmission	*Not Applicable*			*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Diabetes A1c Poor Control for Prime MCE Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP Prime received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Improving the Rate of SDOH Screening for Prime Members*

Table 4-144—2023–2024 PIP Overall Confidence Levels for the *Improving the Rate of SDOH Screening for Prime Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	50%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **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)*.
[3] **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*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving the Rate of SDOH Screening for Prime Members* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP Prime received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *Diabetes A1c Poor Control for Prime MCE Members*

Table 4-145 displays data for RMHP Prime's *Diabetes A1c Poor Control for Prime MCE Members* PIP.

Table 4-145—Performance Indicator Results for the *Diabetes A1c Poor Control for Prime MCE Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
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.	N: 1,788 D: 3,075	58.15%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP Prime reported that 58.15 percent of eligible Prime members ages 18 to 75 years had an HbA1c level greater than 9.0 percent, were missing the most recent HbA1c test result, or did not have an HbA1c test completed during the measurement year.

Nonclinical PIP: *Improving the Rate of SDOH Screening for Prime Members*

Table 4-146 displays data for RMHP Prime's *Improving the Rate of SDOH Screening for Prime Members* PIP.

Table 4-146—Performance Indicator Results for the *Improving the Rate of SDOH Screening for Prime Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible RMHP Prime members who had at least one billed encounter in the measurement year and who completed an SDOH screening.	N: 4,578 D: 44,410	10.31%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP Prime reported that 10.31 percent of eligible RMHP Prime members who had at least one billed encounter were screened for SDOH during the measurement year.

Interventions

Clinical PIP: *Diabetes A1c Poor Control for Prime MCE Members*

Table 4-147 displays the barriers and interventions documented by the health plan for the *Diabetes A1c Poor Control for Prime MCE Members* PIP.

Table 4-147—Barriers and Interventions for the *Diabetes A1c Poor Control for Prime MCE Members* PIP

Barriers	Interventions
• Member understanding of the importance of an annual HbA1c test • Member motivation and activation to establish care with a primary care provider	Diabetes A1c Member Rewards to incentivize members with diabetes for completing an annual HbA1c test
• Lack of access to HbA1c testing for members with SDOH barriers (e.g., transportation, time off work, childcare)	Let's Get Checked—in-home HbA1c testing program
• Provider need for coding education and processes to increase Current Procedural Terminology (CPT) II coding for HbA1c tests and results • Need for clinical workflows that support reducing HbA1c lab values	Primary care value-based payment program to educate and incentivize providers to support members in monitoring and lowering their HbA1c levels

Nonclinical PIP: *Improving the Rate of SDOH Screening for Prime Members*

Table 4-148 displays the barriers and interventions documented by the health plan for the *Improving the Rate of SDOH Screening for Prime Members* PIP.

Table 4-148—Barriers and Interventions for the *Improving the Rate of SDOH Screening for Prime Members* PIP

Barriers	Interventions
• Less engagement from providers when work is not reimbursed • No code specifically set to reimburse screening for SDOH	Provider payment for SDOH screening of members
• High rates of staff turnover require periodic re-training • SDOH screening and intervening appropriately can lead to cumbersome workflows • Need for meaningful storage of SDOH data and communication of information across care teams	Provider coaching on effective and efficient SDOH screening practices

RMHP Prime: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- RMHP Prime followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- RMHP Prime reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

RMHP Prime: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. RMHP Prime addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle, and RMHP Prime received *Moderate Confidence* for the final Module 4 submission. Follow-up on the prior year's PIP recommendations is not applicable.

HEDIS/Core Set Measure Rates and Validation

RMHP Prime: Information Systems Standards Review

According to the HEDIS MY 2023 FAR, RMHP Prime was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted RMHP Prime's performance measure reporting.

RMHP Prime: Performance Measure Results

Table 4-149 shows the performance measure results for RMHP Prime for MY 2021 through MY 2023, along with the percentile ranking for each MY 2023 rate, if available. Rates for MY 2023 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for MY 2023 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Please note that this table presents performance measure rates reported using administrative methodology, while performance measure rates reported using hybrid methodology are presented in Appendix A.

Table 4-149—Performance Measure Results for RMHP Prime

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Breast Cancer Screening				
52 to 64 Years[H]	40.89%	44.34%	50.87%^	WTSA
65 to 74 Years[H]	39.03%	41.15%	51.08%^	BTSA
Cervical Cancer Screening				
Total[H]	42.34%	42.38%	46.96%^	10th–24th
Child and Adolescent Well-Care Visits				
Total[H]	23.86%	28.73%	28.72%	<10th
Childhood Immunization Status				
Combination 3[H]	NA	NA	NA	—
Combination 7[H]	NA	NA	NA	—
Combination 10[H]	NA	NA	NA	—
Chlamydia Screening in Women				
16 to 20 Years[H]	41.67%	39.34%	38.96%	10th–24th
21 to 24 Years[H]	45.10%	49.60%	45.20%	<10th
Colorectal Cancer Screening				
46 to 50 Years[H]	NA	16.69%	22.53%^	BTSA
51 to 65 Years[H]	NA	36.63%	41.17%^	BTSA
66 Years and Older[H]	NA	36.43%	37.74%	BTSA

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Developmental Screening in the First Three Years of Life				
Total[SA]	NA	NA	NA	—
Immunizations for Adolescents				
Combination 1[H]	64.71%	80.00%	58.82%	<10th
Combination 2[H]	8.82%	26.67%	26.47%	10th–24th
Lead Screening in Children				
Total[H]	NA	NA	NA	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total[H]	83.69%	23.40%	20.12%	<10th
Counseling for Nutrition—Total[H]	21.83%	25.96%	32.54%	<10th
Counseling for Physical Activity—Total[H]	76.24%	13.19%	25.44%^	<10th
Well Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	NA	NA	NA	—
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	NA	NA	NA	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years[SA]	33.58%	30.09%	30.83%	BTSA
MMEC—21 to 44 Years[SA]	20.17%	19.57%	19.41%	BTSA
LARC—15 to 20 Years[SA]	6.51%	6.94%	6.77%	BTSA
LARC—21 to 44 Years[SA]	4.87%	4.27%	4.28%	WTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days[SA]	0.00%	NA	NA	—
MMEC—21 to 44 Years—3 Days[SA]	5.77%	6.70%	4.09%	WTSA
MMEC—15 to 20 Years—90 Days[SA]	34.78%	NA	NA	—
MMEC—21 to 44 Years—90 Day[SA]	40.74%	42.16%	38.56%	WTSA
LARC—15 to 20 Years—3 Day[SA]	0.00%	NA	NA	—
LARC—21 to 44 Years—3 Days[SA]	0.00%	0.49%	0.27%	WTSA
LARC—15 to 20 Years—90 Day[SA]	19.57%	NA	NA	—
LARC—21 to 44 Years—90 Days[SA]	16.56%	17.16%	14.31%	WTSA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—21 Years and Older[H]	NA	NA	52.81%	WTSA
Postpartum Care—21 Years and Older[H]	NA	NA	46.54%	WTSA
Timeliness of Prenatal Care—Under 21 Years[H]	NA	NA	NA	—
Postpartum Care—Under 21 Years[H]	NA	NA	NA	—

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years[H]	NA	NA	NA	—
19 to 64 Years[H]	57.22%	59.06%	58.58%	BTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years[H]	NA	NA	NA	—
18 to 64 Years[H]	53.29%	48.05%	54.39%	75th–89th
65 Years and Older[H]	NA	NA	NA	—
Concurrent Use of Opioids and Benzodiazepines				
*18 to 64 Years**[*,SA*]	14.93%	10.26%	9.90%	WTSA
*65 Years and Older**[*SA*]	19.29%	NA	20.00%	WTSA
Controlling High Blood Pressure				
18 to 64 Years[H]	25.22%	22.00%	41.89%^	WTSA
65 to 85 Years[H]	25.37%	23.06%	46.00%^	WTSA
HbA1c A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18 to 64 Years	NA	32.65%	44.11%^	WTSA
HbA1c Control (<8.0%)—65 to 75 Years	NA	40.00%	50.18%^	WTSA
*HbA1c Poor Control (>9.0%)—18 to 64 Years**[H]	69.74%	61.39%	48.01%^	WTSA
*HbA1c Poor Control (>9.0%)—65 to 75 Years**[H]	66.67%	52.31%	40.79%^	WTSA
HIV Viral Load Suppression				
18 to 64 Years[SA]	0.00%	0.00%	0.00%	—
65 Years and Older[SA]	NA	NA	NA	—
Use of Opioids at High Dosage in Persons Without Cancer				
*18 to 64 Years**[*,SA*]	4.11%	3.36%	2.77%	BTSA
*65 Years and Older**[*SA*]	2.48%	NA	NA	—
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[H]	59.11%	60.57%	57.42%	25th–49th
Antidepressant Medication Management				
Effective Acute Phase Treatment—18 to 64 Years[H]	57.44%	62.96%	67.42%^	BTSA
Effective Acute Phase Treatment—65 Years and Older[H]	NA	78.79%	NA	—
Effective Continuation Phase Treatment—18 to 64 Years[H]	39.67%	43.84%	48.41%^	BTSA
Effective Continuation Phase Treatment—65 Years and Older[H]	NA	42.42%	NA	—
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)				
18 to 64 Years[*,H]	58.37%	56.28%	49.49%	WTSA
65 to 75 Years[*,H]	NA	NA	NA	—

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[H]	75.52%	79.22%	80.66%	50th–74th
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years[H]	NA	NA	NA	—
7-Day Follow-Up—18 to 64 Years[H]	38.74%	31.51%	33.24%	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]	54.05%	46.12%	47.96%	25th–49th
30-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years[H]	NA	NA	NA	—
7-Day Follow-Up—18 to 64 Years[H]	NA	21.69%	23.45%	BTSA
7-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
30-Day Follow-Up—13 to 17 Years[H]	NA	NA	NA	—
30-Day Follow-Up—18 to 64 Years[H]	NA	36.11%	36.86%	BTSA
30-Day Follow-Up—65 Years and Older[H]	NA	NA	NA	—
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]	38.84%	33.98%	**27.16%^^**	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]	56.51%	52.65%	48.32%	25th–49th
30-Day Follow-Up—65 Years and Older[H]	38.84%	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	NA	NA	NA	—
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—18 to 64 Years[H]	NA	33.01%	38.85%^	WTSA
Initiation of SUD Treatment—Total—65 Years and Older[H]	NA	36.49%	40.63%	WTSA
Engagement of SUD Treatment—Total—18 to 64 Years[H]	NA	13.65%	15.17%	BTSA
Engagement of SUD Treatment—Total—65 Years and Older[H]	NA	1.35%	1.04%	WTSA
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[H]	47.37%	NA	NA	—
Cholesterol Testing—Total[H]	36.84%	NA	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	34.21%	NA	NA	—
Screening for Depression and Follow-Up Plan				
12 to 17 Years[SA]	7.69%	8.23%	7.86%	WTSA
18 to 64 Years[SA]	7.28%	7.69%	8.32%	WTSA

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
65 Years and Older[SA]	2.37%	2.89%	2.41%	WTSA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total[H]	NA	NA	NA	—
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total[SA]	52.74%	63.56%	71.99%^	BTSA
Rate 2: Buprenorphine[SA]	31.66%	36.44%	37.84%	BTSA
Rate 3: Oral Naltrexone[SA]	4.13%	4.10%	3.19%	WTSA
Rate 4: Long-Acting, Injectable Naltrexone[SA]	0.72%	0.93%	0.37%	WTSA
Rate 5: Methadone[SA]	20.54%	29.17%	36.98%^	BTSA
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years[,SA]*	34.94	41.91	40.95	—
Plan All-Cause Readmissions				
Observed Rate[H]	NA	7.96%	8.98%	—
Expected Rate[H]	NA	9.88%	10.20%	—
O/E Ratio[,H]*	NA	0.8054	0.8809	<10th
PQI 01: Diabetes Short-Term Complications Admission Rate				
18 to 64 Years[,SA]*	27.29	11.13	7.62	—
65 Years and Older[,SA]*	18.41	9.51	5.66	—
PQI 05: COPD or Asthma in Older Adults Admission Rate				
40 to 64 Years[,SA]*	258.84	9.03	5.47	—
65 Years and Older[,SA]*	1,210.72	25.36	14.15	—
PQI 08: Heart Failure Admission Rate				
18 to 64 Years[,SA]*	76.05	5.20	5.81	—
65 Years and Older[,SA]*	1,033.38	28.53	16.98	—
PQI 15: Asthma in Younger Adults Admission Rate				
18 to 39 Years[,SA]*	6.65	2.37	0.34	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

RMHP Prime: Strengths

The following required HEDIS MY 2023 measure rates were determined to be high-performing rates for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2022, or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2022):

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—18 to 64 Years*

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

The following required HEDIS MY 2023 measure rates were determined to be low-performing rates for RMHP Prime (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from MY 2022):

- *Child and Adolescent Well-Care Visits—Total*
- *Chlamydia Screening in Women—21 to 24 Years*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18 to 64 Years*

To address these low measure rates, HSAG recommends RMHP Prime:

- For the *Child and Adolescent Well-Care Visits* measure, incentivize providers, members, and parents to complete well-care visits. RMHP Prime can conduct provider education to ensure providers practice teen-centered care during adolescent visits (e.g., privacy and confidentiality). RMHP Prime can promote well-care visits on social media, as well as during email or text outreach. RMHP Prime can develop partnerships with community stakeholders and utilize Bright Futures materials.[37]
- For the *Chlamydia Screening in Women* measure, RMHP Prime can ensure providers are trained to address sexually transmitted infection (STI) stigma and on how to discuss STI screenings with patients. RMHP Prime can mail a screening card reminder with information on regular women's health checkups such as pap smear and STI screenings. In addition, HSAG recommends that RMHP Prime track chlamydia screening rates and report results to physicians and large practices. RMHP

[37] Centers for Medicare & Medicaid Services. *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits.* Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 13, 2024.

Prime could require lab results to be reported directly to health plans, in addition to usual reports sent to providers.[38]

- For the *Immunizations for Adolescents* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, HSAG recommends RMHP Prime provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. HSAG recommends that RMHP Prime create a provider report that indicates which members have care gaps in this area to help focus outreach for scheduling visits.
- For the *Immunizations for Adolescents* measure, HSAG recommends RMHP Prime work with its providers to ensure they are recording vaccines patients may receive outside of provider care, such as through a pharmacy. RMHP Prime should also consider coordinating vaccine clinics in geographic areas with a high rate of members at convenient hours for families such as evenings or Saturdays.[39,40]
- For the *Follow-Up After Hospitalization for Mental Illness* measure, consider bolstering multidisciplinary coordinated care interventions, as they have been shown to be effective (e.g., HAP, the PCMH, the PBHCI, and the CC Program).[41]

Follow-Up on FY 2022–2023 HEDIS/Core Set Measure Recommendations

FY 2022–2023 Performance Measure Recommendations

In FY 2022–2023, HSAG recommended RMHP Prime:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the MCOs consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

[38] NCQA. Improving Chlamydia Screening. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on: Dec 13, 2024.

[39] Das JK, Salam RA, Arshad A, Lassi ZS, Bhutta ZA. Systematic Review and Meta-Analysis of Interventions to Improve Access and Coverage of Adolescent Immunizations. J Adolesc Health. 2016 Oct;59(4S):S40-S48. Available at: https://pubmed.ncbi.nlm.nih.gov/27664595/. Accessed on: Dec 12, 2024.

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- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- Multiple interventions aimed at pregnant members, including an outreach program for high-risk pregnant members; a partnership with WellHop and SimpliFed for expectant moms to receive additional support during their pregnancies, postpartum period, and with breastfeeding, pumping, and/or formula feeding; a partnership with Empower Health to conduct IVR outreach for low-risk pregnant members to get them scheduled for prenatal and postpartum visits; production of an annual care management newsletter that included information on maternity support programs; and information posted on the RMHP website landing page regarding all maternity programs and supports available. Finally, RMHP arranged for a RAE PCMP to share its best practices for the *Prenatal and Postpartum Care* measure during the January 2024 CQI Newsroom.
- Multiple member outreach campaigns, including: annual member EPSDT notification of benefits letter; monthly IVR and postcard mailing for members who are due for their 1-year-old well visit; IVR calls to close gaps in care for multiple measures; a welcome guide mailed to new members to provide education and recommendations regarding the importance of wellness visits; welcome calls to new enrollees including warm transfer to PCP for appointment to provide education and promote annual well visits; and a monthly postcard mailing for adolescents who missed an immunization between 16 to 18 years of age.
- Establishing an Integrated Quality Workgroup (IQWg) that focuses on interventions for the pediatric population.

HSAG recognizes that the comprehensive focus on maternity interventions, the many modes of member outreach, and the IQWg are likely to help improve and maintain performance rates.

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP Prime Overall Evaluation

Table 4-150 presents the number of elements for each standard; the number of applicable elements within each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-150—Summary of RMHP Prime Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%^
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%~
X. QAPI, CPGs, HIS	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**53**	**1**	**0**	**0**	**98%***

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

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

~ *Indicates no change from review three years prior.*

RMHP Prime: Trended Performance for Compliance With Regulations

Table 4-151 presents, for all standards, the overall percentage of compliance score for RMHP Prime for the most recent year reviewed compared to the previous review and the years each standard was reviewed.

Table 4-151—Compliance With Regulations—Trended Performance for RMHP Prime

Standard and Applicable Review Years	RMHP Prime Average—Previous Review	RMHP Prime Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2019–2020; 2022–2023)	90%	94%
Standard II—Adequate Capacity and Availability of Services (2019–2020; 2022–2023)	100%	92%
Standard III—Coordination and Continuity of Care (2018–2019; 2021–2022)	100%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019; 2021–2022)	86%	100%
Standard V—Member Information Requirements (2021–2022; 2023–2024)*	**89%**	**100%**
Standard VI—Grievance and Appeal Systems (2019–2020; 2022–2023)	86%	94%
Standard VII—Provider Selection and Program Integrity (2020–2021; 2023–2024)*	**94%**	**100%**
Standard VIII—Credentialing and Recredentialing (2015–2016; 2020–2021)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021; 2023–2024)*	**75%**	**75%**
Standard X—QAPI, CPGs, and HIS (2020–2021; 2023–2024)*	**100%**	**100%**
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019; 2021–2022)	100%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	NA**	100%

**Bold text indicates standards that were reviewed in FY 2023–2024.*
***NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, RMHP Prime demonstrated consistent high-achieving scores for three out of four standards reviewed and demonstrated improved scores for two out of four standards reviewed compared to the previous review cycle. Standard IX—Subcontractual Relationships and Delegation maintained the same score from the previous review cycle. Overall, RMHP Prime demonstrated a general to strong understanding of most federal and State regulations.

RMHP Prime: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- RMHP Prime demonstrated a robust contract management process from procurement to execution of subcontractor agreements included monitoring of subcontractor agreements via routine reporting, JOCs, and dashboards.
- RMHP Prime described efforts to support members in rural and frontier areas, such as providing HbA1c and colon cancer testing kits that members can use at home, which lessens the inconvenience of driving to an office for an appointment.

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

HSAG found the following opportunities for improvement:

- Delegate agreements did not include required federal language.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Update its contract to include specific required federal language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended RMHP Prime:

- Provide evidence of a long-term solution for remediating and monitoring retrospective claims denials issues.
- Update language related to authorization timelines in relevant material to clarify that the time frame starts at the time of the request for service.
- Revise its policy to include the correct standards for timely access to care related to urgent services and non-urgent care visit and include the exceptions related to when well-care visits should be scheduled prior to one month.
- Modify relevant materials to remove any references that require a member to submit appeal information in writing.
- Remove language that continuation of benefits must be submitted "in writing" as it is not a requirement of the federal regulations or the State contract.

- Update its Prime member handbook to ensure the members are aware that they must tell RMHP Prime if they want to keep getting services through the appeal process, and it must be requested within 10 days of the NABD.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, RMHP Prime provided evidence regarding long-term updates and monitoring to ensure that member letters related to retrospective claims denials are mailed to members. RMHP Prime updated language in relevant materials related to authorization timelines, removed any references that require a member to submit appeal information in writing, and removed language that continuation of benefits must be submitted "in writing." RMHP Prime updated its policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits and included the exceptions related to when well-care visits should be scheduled prior to one month. Lastly, RMHP Prime updated its member handbook to include information to members regarding how they must request continuation of benefits and it must be done within 10 days of the NABD. HSAG recognized that updating materials and conducting ongoing monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

RMHP Prime: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- RMHP Prime met minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in all contracted counties. RMHP Prime met minimum network requirements for Family Practitioner (MD, DO, NP, CNS) in all but one county, where access was greater than 99.9 percent. 
- RMHP Prime performed strongly in the specialty provider network category, meeting minimum network requirements for General Pulmonary Medicine, Pediatric Cardiology, Pediatric Neurology, Pediatric Ophthalmology, Pediatric Orthopedics, Pediatric Otolaryngology, Pediatric Pulmonary Medicine, Pediatric Urology, General Surgery, and Pediatric Surgery across all contracted counties. 
- RMHP Prime met the minimum network requirements for Pharmacies in 66.6 percent of all contracted counties. In the counties where RMHP Prime did not meet the minimum network requirement, access was 99.3 percent or greater. 
- RMHP Prime established robust processes to research daily and monthly missing or incomplete data from the 834 file, which included its capture of the data on the daily fall-out reports, and manual validation and oversight by the RMHP Prime processors for reconciliation. RMHP Prime verified

the accuracy of all data received through validation checkpoints. RMHP Prime had strong data security, and annual testing was completed.

- RMHP Prime offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via MPP, Inbound Demographic Change Line, Roster Processing, and CAQH ProView.

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

HSAG found the following opportunities for improvement:

- While RMHP Prime met minimum network requirements for Gynecology, OB/GYN (MD, DO, NP, CNS) in greater than 77.7 percent of contracted counties, the plan did not meet the minimum network requirement for Gynecology, OB/GYN (PA) in any contracted counties.
- RMHP Prime did not meet the minimum network requirements for Acute Care Hospitals or Family Practitioner (PA) in more than half (55.6 percent) of all contracted counties.
- No ISCA-specific opportunities were identified.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Conduct an in-depth review of provider categories for which RMHP Prime did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that RMHP Prime continue to conduct an in-depth review of provider categories for which RMHP Prime did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that RMHP Prime:

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies, including a root cause analysis to identify the discrepancy in providers listed in the RMHP Prime data that could not be located in the online provider directory.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- Maintained an open network policy for all providers within its service areas who met its credentialling and quality standards. Given the rural and frontier nature of RMHP Prime's service area, there were few new entrants into the region recently but RMHP Prime had been able to add a small number of new providers. Most notably, RMHP Prime recently added a nurse practitioner staff member in an endocrinology practice in Mesa County, which is a net gain in access.
- Continued to expand its pilot projects for e-consults, which provides PCP access to specialist consultations with providers outside their immediate area, and in some cases outside of the RMHP Prime service area.
- Continued the distribution of quarterly mailings to providers. This mailing asked providers to visit the website and attest, by signing a form, if all information was correct. Or, if inaccuracies existed, to provide RMHP Prime with the updated information.

Based on the above response, RMHP Prime worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2023–2024 was HSAG's first year conducting an ISCA activity as part of NAV for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Encounter Data Validation—RMHP Prime 412 Over-Read

Table 4-152 presents RMHP Prime's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 4-152—FY 2023–2024 Self-Reported EDV Results by Data Element and Service Category for RMHP Prime

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	84.5%	73.8%	77.7%	96.1%
Through Date	85.4%	NA	NA	NA
Diagnosis Code	88.3%	73.8%	77.7%	91.3%
Surgical Procedure Code	88.3%	NA	NA	NA
Procedure Code	NA	72.8%	73.8%	91.3%
Procedure Code Modifier	NA	72.8%	77.7%	96.1%
Discharge Status	85.4%	NA	NA	NA
Units	NA	68.9%	78.6%	96.1%

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

Table 4-153 presents RMHP Prime's FY 2023–2024 EDV over-read case-level and element-level accuracy rates by service category.

Table 4-153—Percentage of Cases in Total Agreement and Percentage of Element Accuracy for RMHP Prime

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	100%	120	100%
Outpatient	20	100%	100	100%
Professional	20	100%	100	100%
FQHC	20	100%	100	100%
Total	**80**	**100%**	**420**	**100%**

RMHP Prime: Strengths

Based on MCO 412 EDV activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- HSAG agreed with 100 percent of RMHP Prime's internal validation results for the total number of individual data elements reviewed. This number is higher than the 98.1 percent agreement rate reported in FY 2022–2023.
- HSAG's over-read results suggest a high level of confidence that RMHP Prime's independent validation findings accurately reflect the encounter data quality summarized in the self-reported service coding accuracy results.
- The self-reported service coding accuracy results showed that all five key data elements for the FQHC cases had accuracy rates greater than 90 percent.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to MCO 412 Audit Over-Read

HSAG found the following opportunities for improvement:

- RMHP Prime noted in the encounter data quality report that it was unable to procure medical records for 63 out of the 412 sampled cases. Seven of the unprocured records were part of the over-read sample. If a high volume of medical records is not procured, the validity of the service coding accuracy report may be affected.

- The data elements reviewed for the outpatient and professional cases were the least likely to be supported by medical record documentation; none of the five data elements for these service categories had a support rate greater than 80.0 percent.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Consider internal data monitoring and provider training to improve medical record documentation.

Follow-Up on FY 2022–2023 Encounter Data Recommendations

FY 2022–2023 Encounter Data Recommendations

In FY 2022–2023, HSAG recommended that RMHP Prime consider internal data monitoring and provider training to improve medical record documentation.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 Encounter Data Recommendations

RMHP Prime reported implementing the following approaches to address encounter data recommendations:

- RMHP Prime reported that RMHP's Quality Assurance department and Program Monitoring and Audit team continued the prior year's process improvements regarding training for reviewers, peer review of all encounter data validation failures at weekly meetings, and use of a standardized audit tool.
- RMHP Prime reported that UnitedHealthcare (UHC) has various program integrity activities to identify and educate providers on billing, coding, and documentation standards.
- RMHP Prime reported that a lack of response to medical record procurement requests contributed to the FY 2022–2023 accuracy rates. Proactive steps were taken during the record procurement process by using multiple methods to request records, increasing the amount of direct provider contact, and offering multiple avenues for record submission.
- RMHP Prime reported that RMHP's Program Monitoring and Audit team provided individualized results of the FY 2022–2023 Annual MCO Encounter Data Quality Review to impacted providers. RMHP Prime reviewers met with individual providers upon request to review failures and provide education on common billing, coding, and documentation errors and best practices.

Based on RMHP Prime's approach to addressing the FY 2022–2023 recommendations, HSAG believes these approaches have the potential to improve encounter data accuracy.

CAHPS Survey

RMHP Prime: Adult CAHPS

Table 4-154 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2021–2022 through FY 2023–2024.

Table 4-154—Adult CAHPS Results for RMHP Prime

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	58.52%	70.48%	54.72% ▼
Rating of All Health Care	49.32%	55.32%	41.61% ▼ ↓
Rating of Personal Doctor	61.24%	73.25%	56.73% ▼ ↓
Rating of Specialist Seen Most Often	71.13%+	65.38%	58.82%
Getting Needed Care	83.61%	86.07%	85.24%
Getting Care Quickly	80.19%	88.65%	79.32% ▼
How Well Doctors Communicate	87.37%	94.67%	90.91%
Customer Service	88.68%+	92.25%+	92.86%+
Coordination of Care	75.64%+	87.50%+	80.72%+
Advising Smokers and Tobacco Users to Quit	63.93%	67.57%	66.34%
Discussing Cessation Medications	54.24%	48.62%	50.00%
Discussing Cessation Strategies	42.37%	46.73%	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.

↑ *Indicates the FY 2023–2024 score is statistically significantly higher than the 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

RMHP Prime: Strengths

The following measures' FY 2023–2024 scores for RMHP Prime were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *Getting Needed Care*
- *Customer Service*
- *Discussing Cessation Strategies*

The following measures' FY 2023–2024 scores for RMHP Prime were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Customer Service*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

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

The following measures' FY 2023–2024 scores for RMHP Prime were statistically significantly lower than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for RMHP Prime were statistically significantly lower than the FY 2022–2023 scores:

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

To address these low CAHPS scores, HSAG recommends RMHP Prime consider:

- Obtaining feedback from members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Involving staff members at every level to assist in improving the member experience.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives.
- Obtaining and analyzing members' experiences with timeliness in scheduling appointments; amount of time spent both in waiting rooms and doctor's offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.

RMHP Prime: Child CAHPS

Due to a low number of respondents, HSAG is unable to present the general child and CCC Medicaid CAHPS results for RMHP Prime in this report (i.e., the results are not reportable).

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To improve member perceptions related to FY 2022–2023 CAHPS results, RMHP Prime reported engaging in the following QI initiatives:

- The member-facing team notified provider advocates and the VBCRC when a healthcare provider was not accepting new patients or were requiring applications for acceptance. Provider advocates followed up with the provider offices to investigate and address member concerns when appropriate. The care management director, a member of the VBCRC, followed up directly with members when needed. VBCRC tracked these actions to evaluate objectively if the practices were meeting the openness to Medicaid requirements outlined in their value-based contracts.
- During member welcome calls, customer service educated members on the importance of having a relationship with a PCP. Customer service asked whether the member had a PCP. If the member did have a PCP, customer service inquired if the member had an upcoming appointment. If the member did not have a PCP, customer service offered to help the member find one and connected the member to the office to schedule an appointment.
- During assessments with members, care coordinators asked whether members had a PCP or other provider and inquired about upcoming appointments. If the member needed assistance finding a provider, the care coordinator supplied information and assisted members in scheduling appointments.
- In the last year, a telehealth platform for members to access clinicians in real time, CirrusMD, was given more promotion in member mailers and emails, as a QR code in existing mailers, and in business cards distributed by care coordinators and external stakeholders.
- Member experience topics were included in newsletter articles, learning collaborative events, and webinar series such as training on leadership, BH skills, and care management.
- Cultural competency training was provided to providers who attended the health equity, care management, and BH skills training sessions.
- The eConsult program was expanded in Mesa County. The goal of this program was to enable primary care clinicians to send consults to specialists via a designated platform designed with the primary care patient in mind. The eConsult platform sends appropriate referrals, supports general satisfaction with providers due to reducing referrals to specialists with long wait times, empowers the primary care practice, and increases education/clinical pathways within primary care.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 CAHPS Recommendations

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

QUIP

Table 4-155 presents RMHP Prime's data element accuracy from baseline through the three months post intervention for all service categories.

Table 4-155—Summary of RMHP Prime QUIP Outcomes

Service Category	Data Element	Baseline	First Month	Second Month	Third Month*
Outpatient Services	Date of Service	89%	88%	100%	100%
	Diagnosis Code	84%	88%	100%	100%
	Procedure Code	87%	88%	100%	100%
	Procedure Code Modifier	89%	88%	100%	100%
	Units	88%	88%	100%	100%
Professional Services	Date of Services	80%	100%	100%	100%
	Diagnosis Code	77%	100%	100%	100%
	Procedure Code	79%	100%	100%	100%
	Procedure Code Modifier	79%	100%	100%	100%
	Units	79%	100%	100%	100%

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

RMHP Prime: Strengths

Based on QUIP activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- RMHP Prime improved its accuracy scores to 100 percent by the end of the QUIP for all data elements in both service categories. Most notably, in month one in the professional services category, all five data elements increased to 100 percent accuracy and maintained 100 percent accuracy through month three.
- Key interventions for the two service categories addressed low outcomes by implementing a policy that reinforced educational attempts with providers and targeted retraction of payments for claims with errors. RMHP Prime notified providers of the possibility of retraction for noncompliance or unsupported billing prior to any recoveries and offered the provider appeal rights upon receipt of the documentation. This policy was still in effect during FY 2023–2024.

- RMHP Prime addressed low outcomes by providing further education to the provider focused on documenting diagnoses correctly and signature guidelines. RMHP Prime reported that the intervention was sustainable due to positive improvements in the accuracy ratings.

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

HSAG found the following opportunities for improvement:

- The identified failure modes included unsupported documentation for the procedure code data submitted, providers selected incorrect diagnosis codes and incorrect units for drug codes based on conditions noted in the medical record, provider did not submit documentation needed to complete audit, and data entered in the EHR that did not authenticate the medical record appropriately.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- Continue to perform ongoing oversight of encounter data to identify errors and to enhance provider relations for opportunities for education, and training to ensure that accuracy rates remain above the 90 percent threshold.

Follow-Up on FY 2022–2023 QUIP Recommendations

FY 2022–2023 QUIP Recommendations

In FY 2022–2023, HSAG recommended that RMHP Prime continue to maintain ongoing oversight of encounter data and enhance provider relations, monitoring, education, and training with providers to ensure that accuracy rates reach and remain above the 90 percent threshold.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 QUIP Recommendations

RMHP Prime reported that it utilizes the monitoring and audit program to perform quarterly audits to educate and train providers. Additionally, RMHP Prime met with providers to educate them on common billing, coding, and documentation errors in hopes that changes would be instituted by the providers prior to the QUIP. RMHP Prime has responded to each component of HSAG's FY 2022–2023 QUIP recommendations. HSAG recognizes that timely and consistent auditing, paired with feedback, is likely to help improve and maintain encounter data accuracy scores.

Mental Health Parity Audit

Table 4-156 displays the MHP Audit compliance scores for RMHP Prime for FY 2023–2024 compared to the FY 2022–2023 compliance scores.

Table 4-156—FY 2023–2024 MHP Audit Score for RMHP Prime

MCO	FY 2022–2023 Total Score	Category of Service	Compliance Score	FY 2023–2024 Total Score
MH/SUD and M/S Services				
RMHP Prime	100%	Inpatient	100%	100%~
		Outpatient	100%	

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

RMHP Prime: Strengths

Based on MHP Audit activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- RMHP Prime demonstrated an overall score of 100 percent.
- RMHP Prime used nationally recognized UR criteria, including MCG, for all MH determinations and ASAM LOCs for all SUD determinations.
- RMHP Prime followed policies and procedures regarding IRR testing and required UM staff members to pass IRR testing annually, including a minimum passing score of 80 percent. All participating staff members passed with a minimum score of 80 percent or better.
- RMHP Prime followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services.
- RMHP Prime staff members reported an increase in average length of stay for SUD low-intensity (ASAM Level 3.1) and high-intensity residential (ASAM Level 3.5) LOCs, and in an effort to decrease provider administrative burden and improve member care, RMHP Prime extended initial authorization from 14 days to 30 days beginning in April 2023.
- RMHP Prime made the denial determinations within the required time frame, and providers were notified of the denial determinations by telephone, secure email, and/or a copy of the NABD for all records reviewed.
- All records reviewed demonstrated that RMHP Prime sent the NABD to the member within the required time frame.

- In all cases reviewed, the denial determination was made by a qualified clinician, and applicable cases contained evidence that RMHP Prime offered a peer-to-peer review to the requesting provider.
- All records reviewed demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system.
- RMHP Prime's NABDs included the required content such as the member's appeal rights, rights to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP Prime in filing an appeal, and access to pertinent records. Additionally, the NABDs included member-specific information and contact information for providers in the area for alternative treatments/services, if applicable.
- During the MHP interview, RMHP Prime staff members reported enhancing documentation of outreach to the member after discharge from ASAM LOC treatments/services so that case managers could better serve the member. RMHP Prime staff members also reported conducting case management meetings while members were in residential/inpatient treatment LOC to increase engagement in case management services, and having dedicated SUD case managers and peer support specialists who follow up with the member post-discharge.

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

HSAG found the following opportunities for improvement:

- Two NABDs reviewed contained medical jargon/terminology.

To address these opportunities for improvement, HSAG recommends RMHP Prime:

- As a best practice, include a plain language explanation next to any medical terminology.

Follow-Up on FY 2022–2023 MHP Recommendations

FY 2022–2023 MHP Recommendations

In FY 2022–2023, HSAG recommended RMHP Prime:

- Conduct staff training and update the NABD template to ensure language regarding the date of the denial determination is used correctly.
- Work with the Department for additional assistance and guidance to ensure that the NABDs are clear and cohesive for the member.

Assessment of RMHP Prime's Approach to Addressing FY 2022–2023 MHP Recommendations

RMHP Prime reported addressing HSAG's recommendations by:

- Including and explicitly specifying both the denial decision date by RMHP Prime and the date(s) of service that are denied within the NABD template.
- Revising the format of RMHP Prime's NABD to improve the transparency, clarity, and effectiveness of communication with the member.

HSAG anticipates RMHP Prime's responses to the recommendations are likely to improve overall processes, communication with the member, and increase MHP compliance. HSAG encourages continuous improvement of member communication letters, including the NABD, to ensure member communication is clear and cohesive. Additionally, RMHP Prime should seek guidance from the Department regarding best practices and continuous improvement in member communications.

QOC Grievances and Concerns Audit

In CY 2023, RMHP Prime investigated 64 potential QOCG cases. RMHP Prime's average membership in CY 2023 was 51,824, with 43,730 members enrolled as of December 31, 2023. Of the 10 QOCG cases submitted by RMHP Prime, seven cases were substantiated.

RMHP Prime: Strengths

Based on QOCG audit activities in FY 2023–2024, HSAG found the following strengths for RMHP Prime:

- During the interview, RMHP Prime staff members explained how, when investigating a potential QOCG, RMHP Prime not only investigates the issue reported, but also other possible issues, if any. RMHP Prime is to then send the provider/facility an LOI with specific questions to ensure that the RMHP Prime staff member investigating understands the situation from all parties involved. Staff members stated that the additional information helps RMHP Prime make the final determination and whether an IAP is needed for the provider/facility.
- RMHP Prime's policy requires the medical director to review any potential *Level 2* or *Level 3* cases. During the interview, RMHP Prime staff members explained that due to an increase in volume and severity of QOCGs from a large provider they have been sending every BH potential QOCG to the medical director for review. Staff members stated that this process is a temporary change made to provide support, training, and oversight for providers.
- The policies and procedures did not specify a time frame for closing QOCG cases. During the interview, RMHP Prime staff members identified an internal goal of closing cases in 90 days or less for RMHP Prime cases and 60 days or less if the case is regarding concurrent/emergent concerns. RMHP Prime reported an average closure time of 47.8 days for the CY 2023 review period, noting

that this is higher than average for BH cases, due to the temporary process of sending each case to the medical director for review regardless of severity.

- Four cases resulted in an IAP. The IAP was either completed upon receipt of the resolution/education letter or was appropriately monitored by the QOC department until it was completed.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- Two of the 10 cases reviewed were submitted by the member or by RMHP Prime staff members on behalf of a member. One case did not meet the member grievance acknowledgement letter timeline of two days, as the acknowledgement letter was sent 13 days after the receipt of the QOCG from the member. The other case did not meet the member grievance resolution timeline of 15 days as the member grievance resolution letter was sent 20 days after the submission of the QOCG from the member.
- The *Quality of Care Investigation, Improvement Action Plan and Disciplinary Actions* policy described how all QOCGs are first screened for any imminent threat to patient safety. If it is determined that an imminent threat to patient safety is present, the issue is to be referred to Quality Intervention Services for follow-up. Although the policy described how QOCGs are screened for imminent threat to patient safety, the policy did not discuss how RMHP Prime is to follow up with the member to determine if the member's immediate healthcare needs are being met, even if they do not meet criteria for imminent threat to patient safety. In follow-up documentation submitted after the interview, RMHP Prime confirmed that member follow-up is completed by the CSA for member grievances only, and QOCGs submitted by internal staff members do not receive member communication.
- The *Rocky Mountain Health Plans PRIME Member Handbook* and the MCE's website included information about the process for filing a grievance. The member materials did not distinguish between a member grievance and a QOCG.

To address these opportunities, HSAG recommends that RMHP Prime:

- Follow outlined member grievance acknowledgement and resolution timelines.
- Update its applicable policies and procedures to include member outreach for all potential QOCGs to ensure that the member's immediate healthcare needs are being met as required in the MCE contract.
- Update its applicable policies and procedures to address the process for notifying the Department when a QOCG has been received and its process for submitting a QOC summary to ensure compliance with the MCE contract.

- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

HSAG did not conduct the QOC Grievances and Concerns Audit for the Medicaid MCEs in FY 2022–2023.

Appendix A. MCO Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for MY 2023 for measures with a hybrid option, along with the percentile ranking for each MY 2023 hybrid rate. Please note that only measures with the same age stratifications between the HEDIS specifications and the Core Set specifications are included.

Table A-1—MY 2023 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Cervical Cancer Screening			
Cervical Cancer Screening	40.81%	47.20%	10th–24th
Childhood Immunization Status			
Combination 3	69.05%	77.86%	≥90th
Combination 7	64.51%	72.51%	≥90th
Combination 10	44.33%	50.85%	≥90th
Immunizations for Adolescents			
Combination 1	63.07%	77.13%	25th–49th
Combination 2	38.97%	43.07%	75th–89th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	67.28%	92.94%	≥90th
Counseling for Nutrition—Total	75.55%	81.27%	75th–89th
Counseling for Physical Activity—Total	74.79%	79.56%	75th–89th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	83.38%	—	—
Postpartum Care	78.59%	—	—
Care of Acute and Chronic Conditions			
Controlling High Blood Pressure			
18 to 64 Years	51.61%	57.32%	—
65 to 85 Years	58.19%	65.06%	—
HbA1c Control for Patients With Diabetes			
HbA1c Control (<8.0%)—18 to 64 Years	48.64%	—	—
HbA1c Control (<8.0%)—65 to 75 Years	54.73%	—	—
*HbA1c Poor Control (>9.0%)—18 to 64 Years**	41.99%	—	—
*HbA1c Poor Control (>9.0%)—65 to 75 Years**	36.66%	—	—

**For this measure, a lower rate indicates better performance.*

— indicates that the rate was not comparable to benchmarks.

Table A-2 shows RMHP Prime's rates for MY 2023 for measures with a hybrid option, along with the percentile ranking for each MY 2023 hybrid rate.

Table A-2—MY 2023 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Cervical Cancer Screening			
Cervical Cancer Screening	46.96%	51.85%	25th–49th
Childhood Immunization Status			
Combination 3	NA	NA	—
Combination 7	NA	NA	—
Combination 10	NA	NA	—
Immunizations for Adolescents			
Combination 1	58.82%	—	<10th
Combination 2	26.47%	—	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	20.12%	83.43%	50th–74th
Counseling for Nutrition—Total	32.54%	82.25%	75th–89th
Counseling for Physical Activity—Total	25.44%	78.11%	75th–89th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	52.18%	90.83%	—
Postpartum Care	46.57%	90.39%	—
Care of Acute and Chronic Conditions			
Controlling High Blood Pressure			
18 to 64 Years	41.89%	73.87%	—
65 to 85 Years	46.00%	68.00%	—
HbA1c Control for Patients With Diabetes			
HbA1c Control (<8.0%)—18 to 64 Years	44.11%	63.59%	—
HbA1c Control (<8.0%)—65 to 75 Years	50.18%	81.48%	—
*HbA1c Poor Control (>9.0%)—18 to 64 Years**	48.01%	26.05%	—
*HbA1c Poor Control (>9.0%)—65 to 75 Years**	40.79%	9.26%	—

**For this measure, a lower rate indicates better performance.*

— indicates that the rate was not comparable to benchmarks.