COLORADO
Department of Health Care Policy & Financing

# Fiscal Year 2020–2021 Accountable Care Collaborative Regional Accountable Entity Virtual Review Aggregate Report

*June 2021*

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

HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Overview

## Background

The Colorado Department of Health Care Policy and Financing (Department) implemented the Accountable Care Collaborative (ACC) program in 2011 as a central part of its plan for Health First Colorado (HFC)—Colorado's Medicaid program—reform. The ACC program was designed to enhance the member and family experience, improve access to care, transform incentives and the healthcare delivery system into a system that rewards accountability for health outcomes, and use available finances more wisely. A key component of the ACC program was partnership with seven Regional Care Collaborative Organizations (RCCOs), each of which was accountable for the program in a designated region of the State. Effective July 1, 2018, pursuant to Request for Proposal 2017000265, the Department executed contracts with the Regional Accountable Entities (RAEs) for the ACC program. The RAEs are responsible for integrating the administration of physical healthcare (previously administered through the RCCOs) and behavioral healthcare (previously administered by behavioral health organizations [BHOs]), and managing networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members.

The RAEs qualify as both primary care case management (PCCM) entities and prepaid inpatient health plans (PIHPs), and as such are required to undergo periodic evaluation to determine compliance with federal Medicaid managed care regulations. The Department elected to complete evaluation of the RAEs' compliance with managed care regulations by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

The RAEs included in this report are: RAE 1, Rocky Mountain Health Plans (RMHP); RAE 2, Northeast Health Partners (NHP); RAE 3, Colorado Access (COA); RAE 4, Health Colorado, Inc. (HCI); RAE 5, COA; RAE 6 and RAE 7, Colorado Community Health Alliance (CCHA).

## Methodology

Between January and May 2021, HSAG performed a virtual review of each RAE to assess compliance with Medicaid managed care regulations and with State contract requirements. The Department requested a review of four managed care standards to evaluate compliance with managed care regulations. The standards chosen were Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a review strategy and monitoring tools based on these four standards to review the performance areas chosen. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*.

This report documents the aggregated results of the RAE virtual reviews to provide a statewide perspective of RAE operations and progress toward achieving ACC program goals. Section 2—Statewide Summary of Results includes a comparison of RAE performance based on aggregated scores of compliance with federal and State managed care requirements. Section 3 includes HSAG's conclusions and overall observations and recommendations related to statewide trends.

# 2. Statewide Summary of Results

## Summary of Compliance With Managed Care Regulations

For the 2020–2021 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements: Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. Compliance review scores for individual standards are included in each region's RAE compliance review report along with details regarding strengths, opportunities for improvement, and trends of required actions based on non-compliance with regulations.

### *Statewide Summary of Compliance Scores for Fiscal Year 2020–2021*

Table 2-1 presents comparative RAE scores aggregated for all standards reviewed in fiscal year (FY) 2020–2021.

**Table 2-1—Summary of FY 2020–2021 Total Scores**

| RAE | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| RAE 1 | 69 | 69 | 67 | 2 | 0 | 0 | 97% |
| RAE 2 | 69 | 68 | 64 | 4 | 0 | 1 | 94% |
| RAE 3 | 69 | 69 | 69 | 0 | 0 | 0 | 100% |
| RAE 4 | 69 | 68 | 64 | 4 | 0 | 1 | 94% |
| RAE 5 | 69 | 69 | 69 | 0 | 0 | 0 | 100% |
| RAE 6 | 69 | 67 | 67 | 0 | 0 | 2 | 100% |
| RAE 7 | 69 | 67 | 67 | 0 | 0 | 2 | 100% |
| **Total** | **483** | **477** | **467** | **10** | **0** | **6** | **98%** |

Overall, scores across the four standards reviewed in FY 2020–2021 were quite high, demonstrating thorough understanding of the regulations. For the seven RAEs, each review contained 69 elements across the four standards. Requirements that were commonly marked as not applicable were either related to moral or religious objections to services or the RAE not having entered into any new delegation agreements in the last 12 months.

## Summary of Scores by Standard

Table 2-2 presents comparative RAE scores for individual standards reviewed in FY 2020–2021.

**Table 2-2—Summary of FY 2020–2021 Scores for Individual Standards**

| RAE | Provider Participation and Program Integrity | Credentialing and Recredentialing | Subcontractual Relationships and Delegation | Quality Assessment and Performance Improvement |
|---|---|---|---|---|
| RAE 1 | 94% | 100% | 75% | 100% |
| RAE 2 | 94% | 94% | 75% | 100% |
| RAE 3 | 100% | 100% | 100% | 100% |
| RAE 4 | 94% | 94% | 75% | 100% |
| RAE 5 | 100% | 100% | 100% | 100% |
| RAE 6 | 100% | 100% | 100% | 100% |
| RAE 7 | 100% | 100% | 100% | 100% |
| **Total** | **97%** | **98%** | **89%** | **100%** |

### Standard VII—Provider Participation and Program Integrity

Both the provider participation and program integrity departments used a mixture of standardized software and reporting tools alongside manual checks as a basis to ensure appropriate monitoring.

Some RAEs received the recommendation to expand the member verification of services methodology to include sampling of minors; although it is more difficult to develop a process in alignment with privacy regulations, minors should be included as part of the sample of members. Some RAEs lacked details regarding how management level and program integrity staff members were trained regarding federal and State standards and requirements. Lastly, despite none of the RAEs reporting any moral or religious objections to services, some RAEs did not state this in member or provider documents and many RAEs did not clarify what a provider should do if a provider has any objections. HSAG recommended including these details within documents such as the member handbook and provider manual or agreement.

### Standard VIII—Credentialing and Recredentialing

The RAEs combined both automated and manual procedures for ensuring compliance. Recommendation trends included more robust mechanisms for verifying credentialing details are consistent with provider directory details and encouraging RAEs to develop an ongoing check for accuracy, rather than just at the initial point of data entry.

### Standard IX—Subcontractual Relationships and Delegation

The lowest scoring standard was Standard IX—Subcontractual Relationships and Delegation, in which the total of only four requirements lead to one *Partially Met* or *Not Met* score heavily impacting overall percentages. The most frequent issue found within this standard was related to the contracts not including clear details stating that the United States Department of Health and Human Services Office of Inspector General (HHS-OIG), Comptroller General, or other designees had the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years.

### Standard X—Quality Assessment and Performance Improvement

Throughout the reviews, RAEs submitted and described clearly outlined policies, procedures, and ongoing improvement initiatives related to each of the four standards. Standard X—Quality Assessment and Performance Improvement was the highest scoring standard overall. In relation to this standard, the RAEs submitted detailed work plans, evaluations, methods to monitor for quality of care, over- and underutilization, outcomes for members with special health care needs, and detailed work flows regarding the health information system requirements.

## *Summary of Credentialing and Recredentialing Record Review Scores*

Table 2-3 presents comparative RAE scores for credentialing records reviewed in FY 2020–2021.

**Table 2-3—Summary of FY 2020–2021 Scores for Credentialing and Recredentialing Record Review**

| RAE | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| RAE 1 | 190 | 166 | 166 | 0 | 24 | 100% |
| RAE 2 | 95 | 75 | 75 | 0 | 20 | 100% |
| RAE 3 | 190 | 161 | 161 | 0 | 29 | 100% |
| RAE 4 | 95 | 75 | 75 | 0 | 20 | 100% |
| RAE 5 | 190 | 161 | 161 | 0 | 29 | 100% |
| RAE 6 | 190 | 161 | 161 | 0 | 29 | 100% |
| RAE 7 | 190 | 161 | 161 | 0 | 29 | 100% |
| **Total** | **1,140** | **960** | **960** | **0** | **180** | **100%** |

Compliance with National Committee for Quality Assurance (NCQA) standards was evident throughout the Standard VIII—Credentialing and Recredentialing record reviews. Policies, procedures, and record samples all indicated that the RAEs performed comprehensive verification checks in a thorough and consistent manner and staff members strictly adhered to recredentialing timelines.

The only recommendations within this standard were in response to one or two samples that included minimal evidence of an individual provider's malpractice insurance (i.e., a letter or email of self-attestation rather than proof of insurance or a cover letter provided from the insurance agency). However, all malpractice sample evidence still met minimum NCQA requirements.

## *Summary of RAE Compliance Scores by Standard Over Three Years*

Table 2-4 presents comparative RAE scores for all standards reviewed from FY 2018–2019 through FY 2020–2021.

**Table 2-4—Summary of Statewide Standards from FY 2018–2019 to FY 2020–2021**

| Standard and Applicable Review Years | RAE 1 | RAE 2 | RAE 3 | RAE 4 | RAE 5 | RAE 6 | RAE 7 | Statewide Average |
|---|---|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services (2019–2020) | 90% | 97% | 80% | 97% | 80% | 83% | 87% | 86% |
| Standard II—Access and Availability (2019–2020) | 100% | 94% | 100% | 94% | 100% | 94% | 94% | 97% |
| Standard III—Coordination and Continuity of Care (2018–2019) | 100% | 91% | 100% | 82% | 91% | 100% | 100% | 95% |
| Standard IV—Member Rights and Protections (2018–2019) | 86% | 100% | 100% | 100% | 100% | 100% | 100% | 98% |
| Standard V—Member Information (2018–2019) | 83% | 100% | 94% | 100% | 94% | 86% | 86% | 92% |
| Standard VI—Grievance and Appeal Systems (2019–2020) | 86% | 77% | 80% | 83% | 83% | 71% | 74% | 79% |
| **Standard VII—Provider Participation and Program Integrity (2020–2021)** | **94%** | **94%** | **100%** | **94%** | **100%** | **100%** | **100%** | **97%** |

| Standard and Applicable Review Years | RAE 1 | RAE 2 | RAE 3 | RAE 4 | RAE 5 | RAE 6 | RAE 7 | Statewide Average |
|---|---|---|---|---|---|---|---|---|
| **Standard VIII—Credentialing and Recredentialing (2020–2021)** | **100%** | **94%** | **100%** | **94%** | **100%** | **100%** | **100%** | **98%** |
| **Standard IX—Subcontractual Relationships and Delegation (2020–2021)** | **75%** | **75%** | **100%** | **75%** | **100%** | **100%** | **100%** | **89%** |
| **Standard X—Quality Assessment and Performance Improvement (2020–2021)** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |
| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019) | 100% | 100% | 88% | 88% | 88% | 75% | 75% | 88% |

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

Of the four standards reviewed in FY 2020–2021, Standard X—Quality Assessment and Performance Improvement had the highest scores for compliance out of any standard since the beginning of the RAE reviews, achieving 100 percent compliance. Standard VIII—Credentialing and Recredentialing reached 98 percent compliance and was the second highest scoring standard (along with Standard IV—Member Rights and Protections, which was reviewed in a previous year). Standard VII—Provider Participation and Program Integrity also scored well, achieving 97 percent compliance. Lastly, Standard IX—Subcontractual Relationships and Delegation was the lowest scoring standard for the current review cycle but was not the lowest scoring standard out of all previous years.

An overview of compliance scores from previous years can be found in the *FY 2019–2020 External Quality Review Technical Report for Health First Colorado*, and further analysis across standards will be presented in the *FY 2020–2021 External Quality Review Technical Report for Health First Colorado* in the fall of 2021.

# 3. Summary of Strengths and Recommendations

HSAG noted the following observations and recommendations related to the four standards reviewed in FY 2020–2021.

## Summary of Strengths

### Standard VII—Provider Participation and Program Integrity

- Most RAEs referenced the "any willing provider" approach related to provider network management and credentialing applications. Many RAEs noted that the existing provider network was stable; having reached the third year of RAE operations, most providers were now within the network.
- Staff members reported new successes such as renewing key contracts and, in some cases, expanding the current providers' capabilities (i.e., telehealth) and service offerings (i.e., substance use disorders [SUDs]).
- Despite the coronavirus disease 2019 (COVID-19) pandemic halting in-person meetings for the majority of calendar year (CY) 2020, provider relations staff members continued to engage providers through regular virtual meetings and in-person meetings, when possible. These meetings provided a venue in which the RAE could share pertinent updates and the providers had the opportunity to collaborate regarding key topics.
  - For example, RAE 1, RMHP, engaged in grassroots efforts for outreach that included attending a variety of local community meetings and events to spread the word about RMHP Medicaid with the goal of reducing the stigma regarding Medicaid. This outreach included "myth busting" educational materials. HSAG identified this as a best practice and recommends that provider relations staff members focus on building provider understanding of the process for contracting with Medicaid to further break down barriers, such as bias against Medicaid.
- Many RAEs used single case agreements (SCAs) as a starting point for engaging a provider with the ultimate goal of securing a contract. Others used the SCA list as a type of "talent pipeline" and resource list to reference and utilize if any specialty needs are identified in the future. HSAG encourages the RAEs to continue to reference the list of SCAs alongside other network adequacy data to assess for trends and possible network gaps.
- Regarding program integrity, many RAEs used streamlined risk assessment tools to monitor, identify, plan, and mitigate fraud, waste, and abuse. The RAEs frequently developed multi-tiered compliance committees to ensure information sharing at the staff, management, and leadership levels.
- While all RAEs required staff members to complete compliance training at time of hire and annually thereafter, some RAEs also hosted a "compliance week," which served as a refresher for any training topics as well as a means of deploying any new ad hoc trainings.

### Standard VIII—Credentialing and Recredentialing

- Each RAE submitted policies and procedures that were strongly aligned with NCQA requirements.
- All sample records submitted for review reached 100 percent compliance for credentialing, recredentialing, and organizational provider credentialing.
- While systems and levels of sophistication varied throughout the RAEs, each maintained the ability to track providers through the application, credentialing, and onboarding process and engage the provider with regular opportunities for training and structured communications.
- The RAEs clearly communicated provider rights related to the credentialing and recredentialing process.
- A key focus in CY 2020, especially toward the end of the year, was onboarding SUD providers in preparation for the onset of the January 1, 2021, benefit expansion.
  - For example, RAE 1, RMHP, noted a prioritized approach to onboarding providers who were identified as highly desirable (i.e., specialists) or in demand (per utilization data). The credentialing staff members aimed to fast-track those applications and focused on communication with these providers to reduce any errors in the application packet and ensure timely application processing.
  - HSAG recognizes this as a best practice and encourages other RAEs to use data and process improvement initiatives to adopt similar time saving methods where possible.
- Credentialing review committees for each RAE included a variety of specialists who were able to conduct peer reviews.

### Standard IX—Subcontractual Relationships and Delegation

- Generally, delegate agreements included language ensuring that ultimate accountability for delegated responsibilities remained with the RAE.
- Although levels of specificity varied, the RAEs each had means of monitoring performance through regular reporting, inter-agency meetings, and annual oversight procedures as necessary.

### Standard X—Quality Assessment and Performance Improvement

- The RAEs developed quality assessment and performance improvement (QAPI) work plans that included high-level explanations of the department, measurements, successes, and ongoing improvement focus areas for each RAE.
- RAE work plans included qualitative and quantitative analysis of the effectiveness of the QAPI program, identified successes and barriers, and set goals for the upcoming time period.
- Mechanisms to detect over- and underutilization were clearly monitored by each of the RAEs. Overutilization was frequently monitored through reports (i.e., top users, emergency department, inpatient, potentially avoidable costs). Underutilization was monitored through the review of complex care management programs and the evaluation of gaps or lack of claims data for members with chronic illnesses or special health care needs.

- RAEs reviewed and updated clinical practice guidelines (CPGs) regularly.
  - Most RAEs communicated updates and/or regular reminders regarding CPGs through provider newsletters and clearly listed CPGs on the RAE's website.
  - To ensure CPGs were consistent with utilization management (UM) practices, RAEs ensured clinical committees review and approve CPGs and compare CPGs alongside UM criteria and procedures.
  - The RAEs frequently ensured that member education materials were reviewed alongside the CPGs, with approval from clinical committees, and considered feedback from member engagement committees. HSAG identified this as a best practice and encourages the RAEs to continue soliciting member feedback regarding member-facing materials.
- Many RAE quality departments described strong coordination with the information technology department and achievements in developing data dashboards for performance goals that were utilized both internally and externally by providers to further communicate successes and ongoing gaps in performance.
- All RAEs submitted extensive documentation outlining the process of data verification, quality assurance, and monitoring of timelines.

## Opportunities for Improvement and Recommendations

### Standard VII—Provider Participation and Program Integrity

- Program integrity/compliance program plans for each RAE included detailed expectations regarding general staff training.
  - However, some RAEs did not include specific expectations for the training of managers and program integrity staff members.
  - HSAG frequently recommended that the RAEs include such training expectations for management-level and program integrity staff members, above and beyond general onboarding and annual all-staff trainings, to ensure managers are specifically equipped to deal with fraud, waste, and abuse issues as they may arise and program integrity staff members have the breadth and depth of knowledge required to develop trainings, policies, and procedures for the organization.
- As part of a comprehensive program integrity plan, RAEs must have a method to regularly verify, by sampling or other methods, whether services billed by providers were actually provided to members. Although most RAEs had operating procedures to do so, some RAEs did not include children within this sample population. While there are understandably additional rules and regulations surrounding this population, HSAG recommended expanding the sampling to include all age ranges of members.

- Although none of the RAEs reported any moral or religious objections to providing services, some did not clearly communicate this within member or provider information.
  - HSAG recommended the RAEs update documents and further recommends instructing providers how to communicate with the RAE if the provider has any objections, so that members may be reassigned to a new provider as needed.
  - A few providers within the RAEs' network had moral or religious objections to providing services; in these instances, HSAG suggests that the provider proactively communicate this to members.
- While the RAEs all operated based on detailed compliance program guidelines that included all-staff training, some RAEs could benefit from adding expectations regarding the timeline for staff members (or contractors) to report suspected fraud, waste, and abuse through the usual lines of communication.
- A few RAEs did not outline accurate details regarding member liability for payment. While members are not liable for any behavioral health services, there are possible co-payments and prescription costs under physical health services, and some liability for RAEs using member handbooks and/or provider manuals for multiple lines of business such as Child Health Plan Plus (CHP+), which may have instances of member liability for out-of-network services without prior authorization.
- While most RAEs noted the influx of SUD providers resulted in the RAE sometimes using the 120-day "grace period" for the State's Medicaid screening and enrollment process, this was outside of normal practice. These RAEs described procedures that were in line with regulations and the allowable 120-day period; however, some RAEs had not made an exception within internal written procedures. HSAG suggests the RAEs expand internal procedures to allow for the additional 120 days.

### Standard VIII—Credentialing and Recredentialing

- HSAG did not identify any required actions related to credentialing, recredentialing, or organizational provider credentialing.

### Standard IX—Subcontractual Relationships and Delegation

- The most common language missing from the RAE delegate agreements was the right for the HHS-OIG, Comptroller General, or other designee to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years.
- Although some RAEs submitted updated templates, in some cases, executed signed contracts had not yet been updated.

### Standard X—Quality Assessment and Performance Improvement

- Although the RAEs reported the ability to retroactively monitor member disenrollment for reasons other than loss of eligibility, HSAG noted that many RAEs did not have an active way of reviewing such information or were generally unclear regarding expectations in relation to this requirement.

  - Although this is a small subset of the overall membership population, these data may contain meaningful information to compare with other quality indicators such as grievances, quality of care concerns, and low member satisfaction scores.
  - HSAG encourages the RAEs to further discuss with the Department expectations for receiving and tracking this specific type of disenrollment data.
- Many RAEs noted a goal of continuing to grow participation at member engagement advisory councils (MEACs).
  - For example, RAE 4, HCI, noted the development of more localized MEAC groups that planned to meet monthly within smaller counties, then send representatives to join the regional quarterly MEAC.
  - HSAG encourages other RAEs to consider additional ways of advertising the MEAC to members and building trust with members for increased, meaningful participation.