COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Accountable Care Collaborative Regional Accountable Entity Virtual Review Aggregate Report

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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 December 2021 and April 2022, 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 III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. HSAG developed a 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, recommendations, and required actions related to statewide trends.

Summary of Compliance With Managed Care Regulations

For the fiscal year (FY) 2021–2022 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements: Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. 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 2021–2022

Table 2-1 presents comparative RAE scores aggregated for all standards reviewed in fiscal year (FY) 2021–2022.

Table 2-1—Summary of FY 2021–2022 Total Scores

RAE	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
RAE 1	41	41	39	2	0	0	95%
RAE 2	41	37	34	3	0	4	92%
RAE 3	41	41	40	1	0	0	98%
RAE 4	41	37	34	3	0	4	92%
RAE 5	41	41	40	1	0	0	98%
RAE 6	41	38	34	4	0	3	89%
RAE 7	41	38	34	4	0	3	89%
Total	**287**	**273**	**255**	**18**	**0**	**14**	**93%**

Overall, scores across the four standards reviewed in FY 2021–2022 were high performing, demonstrating broad understanding of the regulations. For the seven RAEs, each review contained 41 elements across the four standards. Standard V—Member Information Requirements had some requirements scored as *Not Applicable* for four RAEs due to these RAEs using the *Health First Colorado Member Handbook* and not producing a member handbook or supplement. Additionally, two RAEs scored *Not Applicable* for not administering any physician incentive plans that may directly or indirectly reduce or limit services to the member.

Summary of Scores by Standard

Table 2-2 presents comparative RAE scores for individual standards reviewed in FY 2021–2022.

Table 2-2—Summary of FY 2021–2022 Scores for Individual Standards

RAE	Standard III—Coordination and Continuity of Care	Standard IV—Member Rights, Protections, and Confidentiality	Standard V—Member Information Requirements	Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services
RAE 1	100%	100%	89%	100%
RAE 2	100%	100%	86%	86%
RAE 3	100%	100%	94%	100%
RAE 4	100%	100%	86%	86%
RAE 5	100%	100%	94%	100%
RAE 6	90%	100%	87%	86%
RAE 7	90%	100%	87%	86%
Total	**97%**	**100%**	**89%**	**92%**

Standard III—Coordination and Continuity of Care

All RAEs for Standard III—Coordination and Continuity of Care achieved high scores for FY 2021–2022. Multiple departments such as care coordination, utilization management (UM), care management, and customer service all supported efforts in aiding the member with behavioral health and physical health. All RAEs to some extent delegated care coordination activities to accountable providers, provider groups, or care coordination entities within the region. Most RAEs implemented comprehensive policies and procedures to serve all members including those with complex, high-risk, and special health care needs.

Standard IV—Member Rights, Protections, and Confidentiality

The highest scoring standard was Standard IV—Member Rights, Protections, and Confidentiality, in which all seven RAEs scored 100 percent, demonstrating a thorough understanding of the regulations. Throughout the reviews, each RAE submitted and described detailed policies, procedures, and provider and member informational materials that outlined member rights and protections.

Standard V—Member Information Requirements

Standard V—Member Information Requirements was the overall lowest scoring standard across all RAEs. Most RAEs had a few findings that led to *Partially Met* scores for some requirements. The most frequent issues within this standard that caused *Partially Met* scoring were the RAE not including all

required components of a tagline, not updating policy and procedure language to address December 2020 federal language revisions to the timeline for sending members notice of provider termination, and not implementing proper mechanisms to monitor ad hoc printing requests for member informational materials.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Multiple RAEs achieved 100 percent compliance for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Each RAE made best efforts using various methods to inform eligible members about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services such as welcome outreach calls, text message programs, screening assessments, welcome letter and materials, tip sheets, or directing the member to the Department's handbooks. The RAEs used efforts from multiple departments including care coordination, care management, UM, provider relations, customer service, and connecting with community partners and member committees to inform others about EPSDT services.

Summary of RAE Compliance Scores by Standard Over Three Years

Table 2-3 presents comparative RAE scores for all standards reviewed from FY 2019–2020 through FY 2021–2022.

Table 2-3—Summary of Statewide Standards from FY 2019–2020 to FY 2021–2022

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%	88%
Standard II—Access and Availability (2019–2020)	100%	94%	100%	94%	100%	94%	94%	97%
Standard III—Coordination and Continuity of Care (2021–2022)	**100%**	**100%**	**100%**	**100%**	**100%**	**90%**	**90%**	**97%**
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Standard and Applicable Review Years	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Statewide Average
Standard V—Member Information Requirements (2021–2022)	**89%**	**86%**	**94%**	**86%**	**94%**	**87%**	**87%**	**89%**
Standard VI—Grievance and Appeal Systems (2019–2020)	86%	77%	80%	83%	83%	71%	74%	79%
Standard VII—Provider Participation and Program Integrity (2020–2021)	94%	94%	100%	94%	100%	100%	100%	97%
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	94%	100%	94%	100%	100%	100%	98%
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	75%	100%	75%	100%	100%	100%	89%
Standard X—Quality Assessment and Performance Improvement (2020–2021)	100%	100%	100%	100%	100%	100%	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	**100%**	**86%**	**100%**	**86%**	**100%**	**86%**	**86%**	**92%**

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

Of the four standards reviewed in FY 2021–2022, Standard IV—Member Rights, Protections, and Confidentiality had the highest score with 100 percent compliance. Standard III—Coordination and Continuity of Care, the second highest scoring standard in FY 2021–2022, received a score of 97 percent compliance and remains in the top six scoring standards (along with Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement, which were

reviewed in previous years). Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services also scored well, achieving 92 percent compliance. Lastly, Standard V—Member Information Requirements was the lowest scoring standard for the current review cycle but scored higher than the lowest scoring standard out of all previous years, Standard VI—Grievance and Appeal Systems.

An overview of compliance scores from previous years can be found in the *FY 2020–2021 External Quality Review Technical Report for Health First Colorado*, and further analysis across standards will be presented in the *FY 2021–2022 External Quality Review Technical Report for Health First Colorado* in the fall of 2022.

3. Summary of Strengths and Recommendations

HSAG noted the following observations and recommendations related to the four standards reviewed in FY 2021–2022.

Summary of Strengths

Standard III—Coordination and Continuity of Care

- Each RAE submitted policies and procedures that outlined their care coordination programs. Most RAEs had policies and procedures that demonstrated processes for timely coordination of care and promoted continuity of care for all members, including complex, high-risk, and special health care needs members.
- All RAEs had delegated care coordination activities to some extent, engaging with accountable providers, enhanced care providers, provider groups, or care coordination entities within the region. However, the RAEs intervened and assisted the members that required more extensive resources or those with complex and intense health care needs.
- The RAEs discussed the diversified staff members who assist members regarding their care coordination needs including registered nurses, social workers, behavioral health specialists, care coordinators, care navigators, and peer support specialists. The RAEs further discussed other departments that assist with care coordination such as UM, care management, and customer service.
- Care coordinators or customer service agents communicated information to members about their designated care coordinator through telephonic outreach calls, including the name of their care coordinator, contact information, and other ways of accessing care coordination services by contacting the health plan.
- Staff members discussed monitoring primary care medical provider attribution reports received from the Department regularly to verify where members are actively seeking care, identify possible access barriers, and assess the attribution numbers at the provider location level. Many RAEs assisted the member with reattribution by having staff members, such as care coordinators and customer service agents, connect the member to the Health First Colorado enrollment broker.
- All RAEs had processes for reviewing the Department's initial assessment data and conducting additional assessments to determine healthcare needs and the appropriate level of care to build each member's care plan with interventions and goals. The RAEs utilized a variety assessments to further identify additional needs for physical health, behavioral health, or social determinants of health.
- Each RAE utilized and maintained an electronic care coordination tool that collected and aggregated member information including age, gender, race/ethnicity, name of care coordinator, care coordination notes, stratification level, and information that can aid in the creation and monitoring of the member care plan.
- When sharing member information with entities involved in the member's care to promote coordination and continuity of care and reduce duplication, the RAEs shared information through

secure communication information channels (i.e., encrypted emails, fax, telephonic communications). Additionally, service agreements, policies and procedures, and provider manuals outlined the requirements and obligations providers have to maintain and share records in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Standard IV—Member Rights, Protections, and Confidentiality

- Each RAE submitted Members Rights and Responsibility policies that outlined member rights, protections, and confidentiality.
- All RAEs provided materials that informed and outlined the rights of the member such as the member handbook, member newsletters, mailings and emails, website postings, policy statements, provider manual, notices to providers and practitioners, trainings, provider agreements and contracts, or posters at provider office locations.
- While all RAEs informed staff members and providers of member rights, some RAEs also required staff members and providers to read and attest to applicable member rights policies to inform, educate, and ensure compliance.
- Regarding protecting member information, the RAEs provided policies and procedures that demonstrated mechanisms and guidelines for staff members and providers to protect member privacy and confidentiality. Documentation submitted demonstrated compliance with HIPAA requirements. Additionally, the RAEs reinforced protecting member information and confidentiality with required annual privacy trainings for employees.
- Staff members and providers were educated on advance directives through policies, procedures, provider manuals, trainings, and the RAEs' websites. The RAEs outlined expectations and responsibilities for providers and staff members when assisting and supporting members with obtaining information about advance directives. Members and the community received education through the member handbook, informational materials, the member website, or through additional informational sessions held by RAE staff members.

Standard V—Member Information Requirements

- Several RAEs demonstrated robust processes to ensure documents on their websites are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines.
- Policies and procedures submitted outlined expectations and processes for developing effective member informational materials that followed plain language, cultural and linguistic appropriateness, and a sixth-grade reading level.
- Many RAEs described participating and consulting with various member committees to review and test member informational materials to ensure communication is understandable and member friendly.
- Staff members discussed providing member informational materials in non-prevalent languages and formats when requested, including processes for members to receive translated materials or obtain translation services.

- All RAEs' provider directories were available on their respective website and available in a machine-readable format. The provider directories included information such as the provider's name, group affiliation, practice address and telephone number, website address, specialty, Americans with Disabilities Act (ADA) accommodations, linguistic capabilities, whether the provider has completed cultural competency training, and whether the provider is accepting new patients.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

- The RAEs made best efforts in attempting to contact the member within 60 days of enrollment to inform the eligible members of EPSDT services available to them. The RAEs used multiple approaches to inform the member of EPSDT services including welcome outreach calls, text message programs, directing members to the *Health First Colorado Member Handbook*, and supplemental materials. The Department sends the welcome letter and details to access the *Health First Colorado Member Handbook*. Some RAEs sent additional materials such as welcome guides or shortened and customized handbooks. Annually, many RAEs performed additional outreach to members who had not utilized services in the previous 12-month period through additional phone, text, or mail outreach such as well visit reminders.
- RAEs with delegated care coordination entities mostly used chart audits of the delegated care coordination entities to ensure chart documentation, referrals, and services were sufficient to meet the members' healthcare needs.
- Multiple RAEs appropriately referenced the American Academy of Pediatrics' (AAP's) *Bright Futures Guidelines* periodicity schedule as a guide to well visits, screenings, and immunizations throughout the member EPSDT materials. Additionally, materials also stated that services are at no cost to the member and offered assistance to obtain transportation and scheduling appointments. Two RAEs further discussed non-emergency medical transportation, offered by IntelliRide, to members and worked occasionally with Lyft for immediate and unique transportation needs.
- Staff members discussed processes for internal collaboration with multiple departments, including care coordination, care management, customer service/call center staff members, UM, the contracting team, and the provider support team, when helping members arrange EPSDT services.
- The RAEs described utilizing the provider manuals and contract agreements to outline clear EPSDT expectations to ensure screenings are performed by qualified physicians, accurately documented, and billed correctly. The RAEs further described using various communication methods to inform providers about EPSDT services and updates such as policies and procedures, provider newsletters, email notices, trainings, and webinars. One RAE noted working with local partners to develop these trainings.
- Many RAEs worked with community entities and attended county Department of Human Services (DHS) meetings to increase awareness and provide information about EPSDT services.

Opportunities for Improvement and Recommendations

Standard III—Coordination and Continuity of Care

- All RAEs had procedures for providing each member's assigned care coordinator's name and contact information through telephonic outreach; however, HSAG recommended multiple RAEs consider sending a follow-up letter to each member detailing the information provided over the phone.
- Although the RAEs provided detailed overviews of their care coordination programs through reviews, policies, and procedures, two RAEs had an opportunity to improve by enhancing and expanding the language in applicable documents to clearly illustrate roles, responsibilities, and monitoring for those involved in their care coordination delegation model.
- The RAEs described various referral pathways through which a member may enter care coordination, as well as how the referrals are responded to and entered in the system. However, some RAEs could not confirm expected follow-up or outreach methods to a high-risk member. Additionally, after a denial of service, some RAEs could not reference specific processes to refer newly identified members into care coordination. HSAG recommended that these RAEs enhance procedures and create a workflow to ensure appropriate follow-up and outreach to members.

Standard IV—Member Rights, Protections, and Confidentiality

- HSAG identified no opportunities for improvement for this standard.

Standard V—Member Information Requirements

- A common issue across multiple RAEs was not including the statement "within five business days" to inform members that information provided electronically is available in paper form without charge, upon request, and is provided within five business days. HSAG recommended the RAEs align the information across critical materials and websites to inform members. Additionally, the statement should be placed in prominent locations across the website where critical documents are linked and/or downloadable.
- One RAE provided supplemental materials and a formulary list above a sixth-grade reading level. HSAG recommended the RAE enhance the monitoring mechanisms to ensure all required member informational materials are easily understood and use simplified language next to any clinical terminology the RAE does not want to alter.
- While assessing accessibility and Section 508 compliance using the WAVE Web Accessibility Evaluation Tool, HSAG found consistent contrast error issues on the provider directory webpage and member general webpage for two RAEs. HSAG recommended the RAEs expand procedures and reporting mechanisms to address, prioritize, and rectify contrast issues relating to accessibility and Section 508 compliance. HSAG additionally recommended a review of the RAEs' brand guidelines

to accommodate for Section 508 compliance and the consideration of the use of an ADA widget on their websites.

- Some RAEs received recommendations to clarify that members may request the information in large print, Braille, other formats, or on a translation call, *all* of which are at no cost to the member.
- The RAEs had policies and procedures in place that outlined the process for making a good faith effort to send a written notice of the termination of a contracted provider to the member within 15 days after the receipt of issuance of the notice or 30 days prior to the effective date of termination. However, two RAEs did not show monitoring mechanisms to confirm members received the notice within the time limits. HSAG recommended the RAEs develop mechanisms to track and ensure the timeliness of the written notices.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

- HSAG recommended updates within a RAE's EPSDT documents to include:
  - Clarifying language that EPSDT services are available, at no cost, for all members ages 20 and under in its annual EPSDT reminder letter sent to members, member handbook, and EPSDT flier.
  - Clarification that EPSDT services are available to members ages 20 and under.
  - Additional clarifying language in the provider manual that EPSDT services are at no cost to the member and services are covered under the Health First Colorado benefit.
  - The full definition of "medical necessity" and all required details across key documents.
- In addition to the recommended updates within the RAE's EPSDT documents, HSAG recommended capturing providers' resource and referral information into a reference guide or similar type of material for accessing consistent and reliable information that is only retained and accessed by certain staff members.
- EPSDT quarterly outreach reports indicated low success rates for completion for some RAEs; however, these RAEs described not including voicemails in the overall count. HSAG recommended verifying the definition of "completed" outreach with the Department and exploring the addition of voicemails in upcoming quarterly outreach reports as a means to report a whole picture of the RAEs' outreach efforts. Two RAEs' websites contained minor errors such as broken links to the Department's EPSDT information and some EPSDT informational details that included federal citations that were not member friendly. HSAG recommended ensuring the accuracy and readability of website information prior to posting and reviewing links regularly.
- A few RAEs submitted limited documentation to verify how EPSDT considerations are processed within the UM department. HGAG recommended the RAEs 1) enhance documentation and communication procedures with providers regarding what services are available in and out of state and collaborate on care plans when waiting for the level of service required, and 2) expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process and communicated to members, care coordinators, and providers as appropriate.
- Most RAEs described barriers to making residential placements and obtaining respite services for members. The RAEs described ongoing efforts to coordinate between provider relations, contracting,

care coordination, and UM staff members. RAEs noted these barriers often had different methods of informing members/guardians about service delays. HSAG recommended ongoing communication with the Department regarding these service gaps and additional needs, and the RAEs develop communication with members/guardians in accordance with regulations (notice of untimely service).

- During the review of submitted documents, it was disclosed that some RAEs had not outreached non-utilizing members in the previous 12 months during three of the four quarters. While these RAEs did complete outreach to non-utilizers in the last quarter, the RAEs noted an issue with data sorting procedures that led to accidently outreaching members who had utilized services. The RAEs did implement outreach procedures for non-utilizers at the end of calendar year (CY) 2021 and no required action is necessary. However, HSAG recommended revisiting quality assurance procedures regarding this data set.

Required Action Trends

Standard III—Coordination and Continuity of Care

- The RAEs submitted detailed internal care coordination procedures, program descriptions that contained outreach and monitoring expectations, and methods of communicating with entities involved in member care. However, some RAEs delegated a significant percentage of member care coordination through primary care medical provider (PCMP) agreements but did not clearly document expected mechanisms for the PCMP to inform the RAE about high-risk members or when additional support is needed due to the PCMP not offering specific condition management programs. Although these RAEs described communication may occur through email or periodic meetings with the PCMPs and care coordination staff to discuss high-risk members, the RAEs did not clearly describe PCMP expectations regarding referral procedures or timeliness. These RAEs were required to strengthen applicable documents and create a more detailed procedure that outlines referral procedures and timeliness expectations and how the RAEs ensure all member needs are addressed.

Standard IV—Member Rights, Protections, and Confidentiality

- HSAG identified no required actions for this standard.

Standard V—Member Information Requirements

- The RAEs submitted policies and procedures in place to send the member written notice within 15 days of issuance of the provider termination. However, federal language was updated in December 2020 to additionally include “or 30 days prior to the effective date of termination.” RAEs that did not include the additional language “or 30 days prior to the effective date of termination” were required to update their policies and procedures to ensure compliance with federal regulations.
- While the RAEs had policies that described procedures for ensuring member informational materials contained taglines that are consistent with requirements, most RAEs did not include all required

components of a tagline in member informational materials. These RAEs were required to revise and update critical member informational materials to ensure all required components of a tagline.

- The RAEs were required to ensure processes and mechanisms to monitor that, upon request, members are provided with printed materials within five business days and at no cost. Some RAEs did not provide evidence that clearly demonstrated timely monitoring procedures for ad hoc printing requests.
- Four RAEs informed newly enrolled members about services through the Department's welcome letter and the *Health First Colorado Member Handbook*; however, these materials did not contain the RAE's website address as required. The RAEs attempted to communicate with the Department and were each under the impression that the welcome letter used throughout FY 2021–2022 contained the website address details for each managed care entity. The Department plans to update the member welcome letter to include the RAE's website address, and the updated version is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

- Two RAEs did not follow AAP's *Bright Futures Guidelines* time frames for recommended teen well visits. Member EPSDT materials stated two to three years, which should be annual recommended well visits. The RAEs must update applicable EPSDT materials to include the correct *Bright Futures Guidelines* time frame for annual well visits.
- The RAEs were required to complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. However, some RAEs did not consistently complete outreach to members and, when outreach did occur, it was sometimes untimely. Additionally, these RAEs only relied on one communication method to contact non-utilizing members, which only reached a low percentage of members. The RAEs must enhance annual outreach to non-utilizers to ensure it is timely and has a reasonable chance of reaching the member.
- Multiple RAEs had an EPSDT policy that described how outreach to foster care members occurred through DHS case workers; however, these RAEs reported issues identifying the foster care member population in two quarters during the review period, CY 2021. The RAEs could not confirm the process used by DHS to outreach members, did not have a monitoring mechanism to ensure outreach occurred, and did not have a long-term resolution for the foster care data issue. The RAEs must develop a process to ensure access to foster care data and outreach to newly eligible foster children.