COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2024–2025 PIP Validation Report

for

Rocky Mountain Health Plan Prime

April 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

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Acknowledgements and Copyrights

1. Executive Summary

Pursuant to 42 CFR §457.1250, which requires states' Medicaid managed care programs to participate in external quality review (EQR), the State of Colorado, Department of Health Care Policy and Financing (the Department) required its Medicaid health plans to conduct and submit performance improvement projects (PIPs) annually for validation by the State's external quality review organization (EQRO). Rocky Mountain Health Plan Prime, referred to in this report as RMHP Prime, a managed care organization (MCO), holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, the Department's managed care program.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in performance indicator outcomes that focus on clinical or nonclinical areas. For this year's 2024–2025 validation, RMHP Prime submitted two PIPs: *Diabetes A1c Poor Control for Prime MCE [Managed Care Entity] Members* and *Improving the Rate of SDOH [Social Determinants of Health] Screening for Prime Members*. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *Diabetes A1c Poor Control for Prime MCE Members* PIP addresses quality of healthcare and outcomes for RMHP Prime members diagnosed with diabetes. The topic, selected by RMHP Prime and approved by the Department, was supported by historical data. The targeted population includes RMHP Prime members ages 18 to 75 years with a diagnosis of diabetes. The PIP Aim statement is as follows: "Does leveraging member rewards programs, at home A1c testing kits, and primary care provider value-based contract requirements improve Diabetes A1c Poor Control performance for the RMHP Prime MCO population?"

The nonclinical *Improving the Rate of SDOH Screening for Prime Members* PIP addresses quality and accessibility of healthcare and services for RMHP Prime members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP Aim statement is as follows: "Does opening access to utilization of different SDOH tools and data feeds, and implementing intervention activities with multiple tools in a variety of clinical settings, improve overall SDOH screening rates?"

Table 1-1 outlines the performance indicators for each PIP.

Table 1-1—Performance Indicators

PIP Title	Performance Indicator
Diabetes A1c Poor Control for Prime MCE Members	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.
Improving the Rate of SDOH Screening for Prime Members	The percentage of eligible RMHP Prime members who had at least one billed encounter in the measurement year and who completed an SDOH screening.

2. Background

Rationale

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an EQR of each contracting health plan. Health plans include MCOs. The regulations at 42 CFR §438.358 require that the EQR include analysis and evaluation by an EQRO of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the Department—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that RMHP Prime in this report, 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 methods, performance indicator, and data collection methodology) is based on sound 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, an MCO'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 RMHP Prime improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that the MCO executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the MCO during the PIP.

[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: Mar 27, 2025.

Validation Overview

For FY 2024–2025, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCO entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS EQR Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table 2-1—CMS EQR Protocol 1 Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the data needed to conduct the PIP validation from RMHP Prime's PIP Submission Form. This form provides detailed information about RMHP Prime's PIP related to the steps completed and evaluated for the 2024–2025 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects 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 reports 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*.

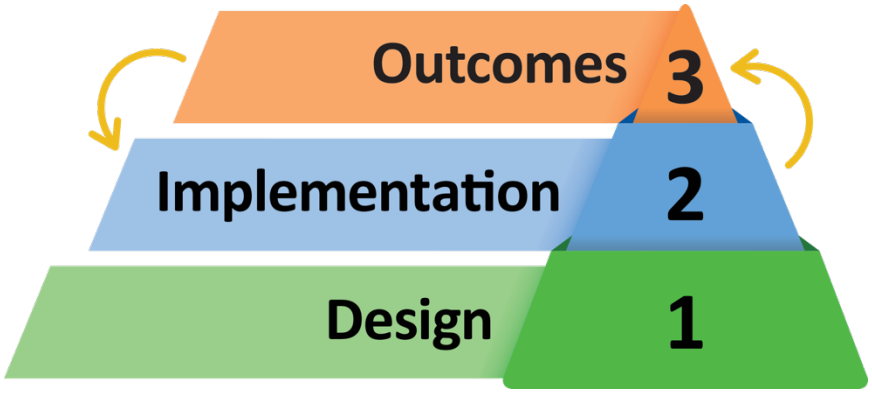
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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.

Figure 2-1 illustrates the three stages of the PIP process—Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the PIP topic, Aim statement, population, sampling techniques, performance indicator(s), and data collection processes. To implement successful improvement strategies, a strong methodologically sound design is necessary.

Figure 2-1—Stages of the PIP Process



Once RMHP Prime establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, RMHP Prime evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, RMHP Prime should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

3. Findings

Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 3-1 summarizes the health plan's PIPs validated during the review period with an overall confidence level of *High Confidence*, *Moderate Confidence*, *Low Confidence* or *No Confidence* for the two required confidence levels identified below. In addition, Table 3-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2024–2025 PIP Overall Confidence Levels for RMHP Prime

PIP Title	Type of Review[1]	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*[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]
Diabetes A1c Poor Control for Prime MCE Members	Initial Submission	93%	89%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Improving the Rate of SDOH Screening for Prime Members	Initial Submission	81%	78%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO 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 all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned 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. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. HSAG assigned a *High Confidence* level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the first remeasurement.

The *Improving the Rate of SDOH Screening for Prime Members* PIP was also validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned 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. For Validation Rating 2, HSAG assigned a *No Confidence* level that the PIP achieved significant improvement. HSAG assigned a level of *No Confidence* for Validation Rating 2 because the performance indicator results demonstrated a decline in performance from baseline to the first remeasurement.

Scores and feedback for individual evaluation elements and steps are provided for each PIP in Appendix B. Final PIP Validation Tools.

Analysis of Results

Table 3-2 displays data for RMHP Prime's *Diabetes A1c Poor Control for Prime MCE Members* PIP.

Table 3-2—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	58.2%	N: 1,255 D: 2,615	48.0%			

* Inverse performance indicator: a lower percentage represents better performance.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, RMHP Prime reported that 58.2 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.

For the first remeasurement period, RMHP Prime reported that 48.0 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. Compared to baseline results, the Remeasurement 1 results demonstrated a statistically significant decrease of 10.2 percentage points in the percentage of eligible members meeting the criteria for Diabetes A1c poor control. This performance indicator is an inverse measure where a lower percentage represents an improvement.

Table 3-3 displays data for RMHP Prime's *Improving the Rate of SDOH Screening for Prime Members* PIP.

Table 3-3—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	10.3%	N: 2,924 D: 43,023	6.8%			

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, RMHP Prime reported that 10.3 percent of eligible Prime members who had at least one billed encounter were screened for SDOH during the measurement year.

For the first remeasurement period, RMHP Prime reported that 6.8 percent of eligible Prime members who had at least one billed encounter were screened for SDOH during the measurement year. Compared to baseline results, the Remeasurement 1 results demonstrated a decrease of 3.5 percentage points in the percentage of eligible members who completed an SDOH screening.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. RMHP Prime's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

Table 3-4 displays the barriers and interventions documented by the health plan for the *Diabetes A1c Poor Control for Prime MCE Members* PIP.

Table 3-4—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.

Table 3-5 displays the barriers and interventions documented by the health plan for the *Improving the Rate of SDOH Screening for Prime Members* PIP.

Table 3-5—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.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, RMHP Prime submitted the clinical *Diabetes A1c Poor Control for Prime MCE Members* PIP and the nonclinical *Improving the Rate of SDOH Screening for Prime Members* PIP. RMHP Prime reported Remeasurement 1 performance indicator results for both PIPs, and both PIPs were validated through Step 9 (Outcomes stage). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages. In the Outcomes stage, the *Diabetes A1c Poor Control for Prime MCE Members* PIP received a *High Confidence* level that the PIP achieved significant improvement and the *Improving the Rate of SDOH Screening for Prime Members* PIP received a *No Confidence* level that the PIP achieved significant improvement.

HSAG's PIP validation findings suggest a thorough application of the PIP Design stage (Steps 1 through 6) for both PIPs. A methodologically sound design created the foundation for RMHP Prime to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. In the Implementation stage (Steps 7 and 8), RMHP Prime accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. In the Outcomes stage (Step 9), Remeasurement 1 results for the *Diabetes A1c Poor Control for Prime MCE Members* PIP demonstrated statistically significant improvement (decrease in an inverse indicator) compared to baseline results. Remeasurement 1 results for the *Improving the Rate of SDOH Screening for Prime Members* PIP demonstrated a decline in performance improvement from Remeasurement 1 to baseline. RMHP Prime will progress to reporting Remeasurement 2 indicator results for both PIPs, and one PIP, *Diabetes A1c Poor Control for Prime MCE Members*, will progress to being evaluated for sustaining significant improvement for next year's validation.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period.

The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Appendix A. Final PIP Submission Forms

Appendix A contains the final PIP Submission Forms provided by RMHP Prime for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submissions.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan PrimeRocky Mountain Health Plan Prime

Demographic Information	
Managed Care Organization (MCO) Name: Rocky Mountain Health Plan Prime	
Project Leader Name: Kim Herek	Title: Quality Improvement Director
Telephone Number: 402-917-1833	Email Address: Kimberly.herek@uhc.com
PIP Title: *Diabetes A1c Poor Control for PRIME MCE Members*	
Submission Date: 10/31/2023	
Resubmission Date (if applicable): 1/22/2025	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic:
Diabetes A1c Poor Control for PRIME MCE Members

Provide plan-specific data:
For 7/1/2022-6/30/2023, the Diabetes A1c Poor Control rate for RMHP PRIME Members was 58.15% using only administrative claims data. This is an inverse measure where a lower rate indicates better performance. Although RMHP performs better using hybrid measure specifications on a calendar year timeframe, there are opportunities to improve administrative data performance. By improving administrative data performance, this will allow RMHP to more accurately identify Members who could benefit from care management services, diabetes quality programs and incentives, and other population health initiatives.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:
By improving performance on Diabetes A1c poor control, it supports improving member health and satisfaction in the following ways:

- Fostering and/or strengthening relationships between the Member with diabetes and primary care providers with their care teams. This improves member satisfaction and patient activation.
- Lower A1c lab values result in less long-term complications, comorbidities and/or premature death.
- Lower A1c lab values supports preventable hospitalizations, emergency department utilization and other healthcare utilization thus lowering healthcare spend
- Where applicable, behavioral health and/or dental health may be integrated into well diabetes chronic condition encounters to support whole person health care

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

- Does leveraging member rewards programs, at home A1c testing kits, and primary care provider value-based contract requirements improve Diabetes A1c Poor Control performance for the RMHP PRIME MCO population?

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition:

PRIME Members ages 18-75, as of December 31 of the measurement year who have been diagnosed with Diabetes by either claim or encounter data and by pharmacy data. Plans must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Enrollment requirements (if applicable):

No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Member age criteria (if applicable):

Ages 18 to 75 as of December 31 of the measurement year. Anchor date: December 31 of the measurement year.

Inclusion, exclusion, and diagnosis criteria:

Event/diagnosis:

- Claim/Encounter Data: Beneficiaries who met any of the following criteria during the measurement year or year prior to the measurement

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

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The population definition must:

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- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

year (count services that occur over both years)
  - At least one acute inpatient encounter with a diagnosis of diabetes without telehealth
  - At least one acute inpatient discharge with a diagnosis on the discharge claim
  - At least two outpatient visits, observation visits, telephone visits, e-visits, virtual check ins, ED visits, nonacute inpatient encounters or nonacute inpatient discharges. Visit type need not be the same for the two encounters.
- Pharmacy Data
  - Beneficiaries who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior to the measurement year
- Required Exclusions: Beneficiaries who meet any of the following criteria
  - Beneficiaries who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement period and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid induced diabetes, in any setting, during the measurement period or the year prior to the measurement year.
  - Beneficiaries in hospice or using hospice services anytime during the measurement year.
  - Beneficiaries receiving palliative care.
- Optional Exclusions:

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

  - Exclude beneficiaries who meet the following criteria: Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded:
    - At least one claim/encounter for frailty during the measurement year
    - Any of the following during the measurement year or the year prior to the measurement year: At least two outpatient visits, observation visits, telephone visits, e-visits, virtual check ins, ED visits, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service with an advanced illness diagnosis.. Visit type need not be the same for the two encounters.
    - A dispensed dementia medication

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):

Value Set OIDs. See accompanying Excel spreadsheet for individual billing codes.

- 2.16.840.1.113883.3.464.1004.1810
- 2.16.840.1.113883.3.464.1004.1465
- 2.16.840.1.113883.3.464.1004.1077
- 2.16.840.1.113883.3.464.1004.1105
- 2.16.840.1.113883.3.464.1004.1086

Appendix A: State of Colorado 2024-25 PIP Submission Form
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Performance Improvement Projects

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

- 2.16.840.1.113883.3.464.1004.1530
- 2.16.840.1.113883.3.464.1004.1531
- 2.16.840.1.113883.3.464.1004.1532
- 2.16.840.1.113883.3.464.1004.1533
- 2.16.840.1.113883.3.464.1004.1756
- 2.16.840.1.113883.3.464.1004.1761
- 2.16.840.1.113883.3.464.1004.1762
- 2.16.840.1.113883.3.464.1004.1395
- 2.16.840.1.113883.3.464.1004.1189
- 2.16.840.1.113883.3.464.1004.1398
- 2.16.840.1.113883.3.464.1004.1191
- 2.16.840.1.113883.3.464.1004.1446
- 2.16.840.1.113883.3.464.1004.1202
- 2.16.840.1.113883.3.464.1004.2225
- 2.16.840.1.113883.3.464.1004.1450
- 2.16.840.1.113883.3.464.1004.2224

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Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Performance Improvement Projects

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply. **The population definition must:** ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. ◆ Include the age range and the anchor dates used to identify age criteria, if applicable. ◆ Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3. ◆ Capture all members to whom the statement(s) applies. ◆ Include how race and ethnicity will be identified, if applicable. ◆ If members with special healthcare needs were excluded, provide the rationale for the exclusion.
- 2.16.840.1.113883.3.464.1004.1445 - 2.16.840.1.113883.3.464.1004.1460 - 2.16.840.1.113883.3.464.1004.1246

Appendix A: State of Colorado 2024-25 PIP Submission Form
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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

Sampling methods were not used.

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	CMS Core Measure –Diabetes A1c Poor Control – NQF0059 *Inverse Measure
	The CMS Core Measure – Diabetes A1c Poor Control – NQF 0059 was selected because it is a nationally developed and recognized measure. CMS states that the Adult Core Set includes quality measures that assess the overall national quality of care for beneficiaries, monitor performance, and improve the quality of health care. By selecting this nationally recognized measure, it improves RMHP's ability to benchmark, conduct analysis, implement interventions, and monitor performance over time.
Numerator Description:	PRIME Members with the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year
Denominator Description:	PRIME Members ages 18-75, as of December 31 of the measurement year who have been diagnosed with Diabetes by either claim ore encounter data or by pharmacy data
Baseline Measurement Period	07/1/2022 to 06/30/2023 using 2023 CMS Core Measure Technical Specifications
Remeasurement 1 Period	07/1/2023 to 06/30/2024 using 2024 CMS Core Measure Technical Specifications
Remeasurement 2 Period	07/1/2024 to 06/30/2025 using 2025 CMS Core Measure Technical Specifications
Mandated Goal/Target, if applicable	N/A
Use this area to provide additional information.	

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data	[X] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 99.83% complete.	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: a. Identify the claims (both paid and IBNR) by Date of Service (DOS) and Input Date (date entered into the claims payment system) b. Pivot data into a table by DOS and Input Date and calculate the percentage of claims input within 60 days and 90 days from the DOS as compared to the total number of claims to date by DOS month (claims input within 60 or 90 days divided by total claims to date) c. Calculate the average completeness across months by 60 and 90 days (% complete for month averaged across all months) d. Calculate the Fiscal Year Completeness with 60 days runout (sum of all fiscal year claims through 2 months after the end of the fiscal year divided by the sum of all claims collected for the fiscal year). This rate will change as we receive additional claims, but by no more than an estimated 7-8% (determined by the average lag by month). Note this is not the impact on the measures, only on data completeness of administrative data. e. Impact on Rates calculated by taking the HEDIS rate calculation for the month following the end of the fiscal year (July 2023) compared to the most recent run of HEDIS rates (October 2023).	

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Data Elements Collected: Data elements collected are determined by the CMS Core Measure Specifications. **Data Collection Process:** a. Claims and Enrollment are extracted from the payment and enrollment systems and loaded into the HEDIS software managed by Inovalon. b. Data is monitored for load and trend accuracy. Any errors are fixed and reloaded. c. HEDIS analytics are then run in the software to produce rates. d. Rates are extracted out of the software using built-in tools. e. Data is loaded into RMHP SQL servers and validated for accuracy. Denominator and numerator data is available at a member and measure level. f. Data is then produced in aggregate for reporting, validated against software rates.

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: CMS Core Measure – Diabetes A1c Poor Control – NQF 0059 *Inverse Measure

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022–06/30/2023	Baseline	1788	3075	58.15%	N/A	N/A for baseline
07/01/2023–06/30/2024	Remeasurement 1	1255	2615	47.99%	N/A	Chi-square; Two-tailed, Extremely Statistically Significant $p = 0.0001$
07/01/2024–06/30/2025	Remeasurement 2					

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative: The baseline findings for Indicator 1 demonstrate that 58.15% of PRIME RMHP Members do not complete an A1c test or have an A1c>9 during the measurement timeframes per administrative data. This data analysis was conducted by using administrative claims data to identify and calculate eligible Members and the number of Members who received an A1c with an associated lab value per the measure specifications. An identified factor that threatens the validity of the data is that the CMS Core Measure is intended to have measurement years based on the calendar year.

Baseline to Remeasurement 1 Narrative: The Remeasurement 1 findings for Indicator 1 demonstrate that 47.99% of PRIME RMHP Members do not complete an A1c test or have and A1c>9 during the measurement timeframes per administrative data. This data analysis was conducted by using administrative claims data to identify and calculate eligible Members and the number of Members who received an A1c with an associated lab value per the measure specifications. For Indicator 1, a lower performance rate is better. Performance for Indicator 1 has improved and shown extremely statistically significant improvement.

Baseline to Remeasurement 2 Narrative:

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

QI Team Members: Clinical Quality Performance Manager, Clinical Program Managers, Clinical Quality RN, and Data Analysts

This team of staff is comprised of staff from Rocky Mountain Health Plans. RMHP's Clinical Quality Performance Manager leads this effort with intervention support from RMHP's Clinical Quality RN and Clinical Program Managers. They are supported by an internal data analyst to review data, identify gaps, and monitor data on an ongoing basis.

QI process and/or tools used to identify and prioritize barriers:

Diabetes A1c Poor Control is a prioritized measure for RMHP. The QI team hosts monthly meetings, Internal Quality Workgroups (IQWgs), to discuss barriers, identify improvement areas, and implement interventions for all prioritized measures. From the IQWg discussions and data analysis, the QI team and senior leaders determined that a major barrier to increasing Diabetes A1c Poor Control is access to A1c testing for Members with diabetes who have social determinants of health (SDoH) barriers, Member motivation/understanding to receive annual diabetes testing, and primary care provider coding and clinical workflows that support reducing A1c lab values.

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Diabetes A1c Member Rewards	- Member understanding of the importance of an annual A1c - Member motivation and activation to establish care with a primary care provider
Let's Get Checked – In Home A1c Testing	- Access to A1c testing for Members with SDoH barriers (ie. transportation, time off work, childcare, etc.)
Primary Care Value Based Payment Program	- Coding education and processes to increase CPT II coding - Clinical workflows that support reducing A1c lab values

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

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Improving the Rate of SDOH Screening for PRIME Members
for Rocky Mountain Health Plan Prime

Demographic Information	
Managed Care Organization (MCO) Name: Rocky Mountain Health Plan Prime	
Project Leader Name: Kimberly Herek	Title: Director of Quality Improvement
Telephone Number: 402-917-1833	Email Address: Kimberly.Herek@uhc.com
PIP Title: Improving the Rate of Social Determinants of Health (SDOH) Screening for PRIME Members in Region 1	
Submission Date: 10/31/2024	
Resubmission Date (if applicable): 1/22/2025	

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Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
PIP Topic: **Increase screening rates for SDoH in the total PRIME patient population** **Provide plan-specific data:** RMHP has observed a decline in SDoH screening rates after the end of the Accountable Health Communities Model (AHCM) in 2022. Plan-specific rates demonstrating baseline and Remeasurement Year 1 are reported below in section 7. **Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:** Growing evidence shows that addressing unmet SDoH needs like homelessness, hunger, and exposure to violence, can mitigate the harm of situational factors to a person's overall health. As with clinical assessment tools, providers can use the results from SDoH screening tools to inform patients' treatment plans and make referrals to community services.

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Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s): Does opening access to utilization of different SDoH tools and data feeds, and implementing intervention activities with multiple tools in a variety of clinical settings, improve overall SDoH screening rates?

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply. **The population definition must:** ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. ◆ Include the age range and the anchor dates used to identify age criteria, if applicable. ◆ Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3. ◆ Capture all members to whom the statement(s) applies. ◆ Include how race and ethnicity will be identified, if applicable. ◆ If members with special healthcare needs were excluded, provide the rationale for the exclusion.
Population definition: All unique Members enrolled in PRIME at any point in the measurement year **Enrollment requirements (if applicable):** Enrollment is defined by the State of Colorado's Member enrollment, attribution, and assignment processes described in Section 6.1 of the contract: Medicaid eligible members in PRIME Service Area (see 3.0 Program Geography), within the 31 aid categories defined in the contract. **Member age criteria (if applicable):** per State PRIME contract **Inclusion, exclusion, and diagnosis criteria:** all Members enrolled in PRIME for the measurement year, in accordance with State eligibility criteria **Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):** per PRIME contract

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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample: Sampling was not used as it was not permitted for the non-clinical SDoH Performance Improvement Plan.

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	**SDoH Screening Rate for Unique Members in Clinical Settings**
	The improvement of SDoH screening rates is a mandated PIP topic for SFY25. RMHP is defining the performance indicator as screening rates for *unique* members, which will produce more precise results (versus reporting an overall count of SDoH screeners); this will allow for an analysis of screening patterns to inform future interventions to improve screening rates. This indicator (and overall PIP strategy) is specific to SDoH screeners completed in the clinical setting at in-network provider facilities and is separate from/does not include RMHP's Care Management strategy to improve SDoH screening rates.
Numerator Description:	Number of unique members with a completed SDoH screener in the measurement year
Denominator Description:	Number of enrollees in PRIME during the measurement year who had at least one billed encounter in the measurement year
Baseline Measurement Period	07/1/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	N/A
Use this area to provide additional information. N/A	

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data	[X] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data ____ [X] Other __Health Information Exchange_ [X] Other __State 834 files & 820 files___ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

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	Estimated percentage of reported administrative data completeness at the time the data are generated: _100_ % complete. **Description of the process used to calculate the reported administrative data completeness percentage**. The data collected to report the numerator of the performance indicator was derived from SDoH screener data from QHN and state enrollment files. The screener data was transferred to the RMHP SQL Server in a daily feed. The numerator reported in the baseline data was gathered in September 2024 for the measurement period ending on June 30th, 2024; since RMHP received screener data in a daily feed and the baseline report was compiled a full month after the end of the measurement period, all available screens in QHN were captured and can be considered a complete data set. As additional layer of data validation for matching a SDoH screener with the member, the screener data that was merged with State enrollment files was scrubbed using a hierarchy of member identification factors (Medicaid ID, DOB, first/last name, address) to match the screeners to members. Screeners that could not be matched to a unique member were not included in the baseline or remeasurement data (resulting in 100% completeness rate for screener-to-member match for this component of the data set). **Include a narrative of how claims lag may have impacted the data reported:** Claims data used to complete the denominator is pulled at least	

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	120 days after the end of the measurement year, thus allowing ample time for claims lag.	

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Data Elements Collected: For the first remeasurement period, completed SDoH screeners and RMHP member enrollment data were the two elements collected. **Data Collection Process:** • The RMHP Data Analytics team extracted SDoH screening data for screeners that occurred within the 12-month reporting period (July 1, 2023 – June 30, 2024) from the RMHP SQL Server. • This data was merged and matched to the internal membership files (834 and 820 files) according to line of business (RAE), using the Medicaid ID provided in the SDoH screening data. A scrub was completed comparing the Medicaid ID and member identification factors (DOB, first/last name, address) to validate that the member demographic information included with the SDoH screener is correct and that the member was enrolled in the respective Medicaid plan on the screening date. • The data was pivoted into a table that produced SDoH screening totals • The numerator data (count of SDoH screeners) was deduplicated by unique member in the final remeasurement report • In addition to the AHCM screener reported at baseline, the PIP interventions and data reported in remeasurement years will be incorporating different tools selected by providers. All SDoH screeners will be evaluated to ensure that the tool is addressing the four required domains; blank copies of the SDoH screeners will be provided with each PIP remeasurement submission. • Using the State 834 and 820 files, enrollment numbers for the applicable line of business were totaled by unique Medicaid ID, producing the denominator for the performance indicator; using this list, the data was further filtered using claims data to produce a list of unique enrollees who had at least one encounter during the measurement period

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: SDoH Screening Rate for Unique Members in Clinical Settings

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022-06/30/2023	Baseline	4,578	44,410	10.31%	N/A for baseline	N/A for baseline
07/01/2023-06/30/2024	Remeasurement 1	2,924	43,023	6.80%	N/A for RMY1	Used Chi-square with Yates Correction statistical test; Chi square equals 343.193 with 1 degrees of freedom; the two-tailed P value is less than 0.0001
07/01/2024-06/30/2025	Remeasurement 2					

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Improving the Rate of SDOH Screening for PRIME Members
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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative: SDoH screening rates remain low at 10.31% after an observed downward trend following the end of the Accountable Health Communities Model (AHCM) demonstration in 2022. A key assumption to explain the decrease in screening rates is the termination of AHCM programmatic support including deployment and QI coaching, staff training, financial incentives, and technical assistance with electronic screening tools. With the termination of AHCM, new SDoH screening tools will be introduced for use in the clinical setting based on provider requests. It is anticipated this will have statistical impact on the remeasurement data (e.g. new reports are being built to accommodate the different tools, and data will likely be consolidated from multiple sources).

Baseline to Remeasurement 1 Narrative: In Remeasurement Year 1, the SDoH screening rate decreased by 3.51%. A Chi-Square with Yates Correction statistical test was used, yielding a chi-square value of 343.193 with 1 degrees of freedom. The two-tailed P value is than 0.0001, which is considered to be statistically significant. This decline may be attributed to the residual effects of the AHCM pilot's conclusion, as PRIME practices were the primary focus for interventions during the pilot. This focus could explain the higher baseline rate compared to other lines of business. Additionally, the overall results were affected by the delay in establishing the payment methodology for providers as an incentive to screen for SDoH. This delay also postponed the communication to providers regarding the payment; Providers were informed of the payment policy for SDoH screeners on March 29, 2024,

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Improving the Rate of SDOH Screening for PRIME Members
for Rocky Mountain Health Plan Prime

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

and the policy went into effect on May 1, 2024. Consequently, providers had two months remaining in the Remeasurement Year (Fiscal Year 23-24) to establish or streamline previous SDoH screening workflows and build the necessary technological infrastructure with to capture the results.

Baseline to Remeasurement 2 Narrative:

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

QI Team Members: Clinical Program Manager specializing in Integrated Behavioral Health, Strategy and Program Manager, Data Analysts, Data Management Partners from Quality Health Network (QHN)

This team is mostly comprised of staff from Rocky Mountain Health Plans with some additional support from our data management partners at Quality Health Network (QHN). RMHP's Strategy and Program Manager leads this effort with intervention support from RMHP's Clinical Program Manager specializing in Integrated Behavioral Health. They are supported by an internal data analyst to review current data feeds, identify gaps, and monitor data on an ongoing basis. Senior leaders at RMHP have provided strategy support for policy development, especially as it pertains to payment.

QI process and/or tools used to identify and prioritize barriers:

The QI team reflected upon lessons learned from the Accountable Health Communities Model (AHCM) program, which ended in 2022, incorporating feedback from providers, staff members, and other key stakeholders. They reviewed data for rates of screening during the AHCM program and compared to rates of screening after AHCM had ended, noted that rates of screening were trending downwards now that there was not programmatic support to encourage this effort. The QI team and senior leaders determined that a major barrier to increasing screening rates could be addressed by providing reimbursement for SDOH screening comparable to that for depression screening and providing access to additional screening tools.

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Payment for SDOH Screening	• Less engagement from providers when work is not reimbursed • No code specifically set to reimburse screening for SDOH
Provider Coaching	• 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

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Improving the Rate of SDOH Screening for PRIME Members
for Rocky Mountain Health Plan Prime

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Appendix A1. Intervention Worksheets

Appendix A1 contains the completed Intervention Worksheets that RMHP Prime provided for validation. HSAG made only minor grammatical corrections to these forms and did not alter the content/meaning.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan Prime
PIP Title	*Diabetes A1c Poor Control for PRIME MCE Members*
Intervention Title	Diabetes A1c Member Rewards Program

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	**Diabetes A1c Member Rewards Program**		
What barrier(s) are addressed?	Member understanding of the importance of an annual A1c Member motivation and activation to establish care with a primary care provider		
Describe how the intervention is culturally and linguistically appropriate.	Incentive and educational information is offered in Spanish. When a Member outreaches to Customer Service, additional languages are available.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Identify eligible population.		
	2. Collaborate with UnitedHealthcare Member Rewards team to ensure marketing materials are acceptable.		
	3. UnitedHealthcare Member Rewards team sends out Member incentive information with education.		
	4. UnitedHealthcare Member Rewards team and RMHP monitor progress.		
Intervention Start Date	**05/01/2023**	**Intervention End Date**	**06/30/2024**

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**Member Incentive Rate of Return**		
Numerator description (narrative)	**# of Members who received the A1c Incentive**		
Denominator description (narrative)	**# of Members who were eligible to receive the A1c Incentive**		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
05/01/2023-12/31/2023	**158**	**2,879**	**5.49%**
05/01/2024-12/31/2024	**TBD**	**TBD**	**TBD**
05/01/2025-12/31/2025	**TBD**	**TBD**	**TBD**
If qualitative data were collected, provide a narrative summary of results below.			
In 2023, Prime Member rewards were transitioned from an internal process at RMHP to a vendor at UnitedHealthcare (UHC) called Taylor Member Rewards. Based off the final performance Rate of Return (RoR), the program demonstrated an overall increase in RoR from 2022 at 3.32% to 5.49% in 2023.			

***Appendix A1-1*: State of Colorado PIP Intervention Worksheet**
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
In 2022 and prior years, a reminder letter, with an additional incentive opportunity, was sent in the Fall to eligible Members who still had an A1c gap in care which was identified using claims data. In 2023, this additional reminder letter was not sent to Members and still a higher rate of return in the program was demonstrated. Based on the increased RoR in 2023, it was determined that it may not be as beneficial to send a second reminder letter with the additional incentive opportunity; but rather the initial comprehensive Diabetes care letter was sufficient. This is a significant savings in both time and resources.
What challenges were encountered?
Due to RMHP no longer directly sending the incentives, the challenge encountered was identifying the correct contact and access to the Member rewards reports in order to monitor RoR. The team had to engage with the vendor and contacts at UHC to ensure that RMHP Medicaid Members were being tracked appropriately and accurately so as to monitor this intervention and its impact accordingly. Additionally, marketing and communication policies were updated during 2024 which led to delays in creating and approving Member facing materials.
How were the challenges resolved?
RMHP identified the Medicaid Member rewards contact and met with them to receive training on the new process and to ensure we had access to all the appropriate reports. Standing meetings were established which also helped to resolve communication barriers.
What successes were demonstrated through the intervention testing?
There was an informative letter sent to Members educating on the opportunity to receive rewards if they complete their diabetic A1c testing earlier in the year compared to 2022. In addition, RMHP requested Members have their care provider fill out and sign the incentive form and mail/fax back to RMHP, compared to UnitedHealthcare who verifies services off claims and the rewards money gets automatically added to a gift card. Both the letter and simplifying the process, could have been contributors in the increase of RoR for 2023.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon **X** Continue
Rationale for Intervention Status Selected
The rewards program is a great incentive for Members to stay motivated to complete their annual preventive screenings/tests, exercise, and promote healthy lifestyle choices. RMHP saw an increase in the annual RoR with the migration of the rewards program to UHC. The annual RoR of 5.49% is remains higher than RMHP's goal of 4%. For these reasons, RMHP will continue this intervention.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan Prime
PIP Title	*Diabetes A1c Poor Control for PRIME MCE Members*
Intervention Title	Let's Get Checked – In Home A1c Testing

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Performance Improvement Projects

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	**Let's Get Checked – In Home A1c Testing**		
What barrier(s) are addressed?	Access to A1c testing for Members with SDoH barriers (ie. transportation, time off work, childcare, etc.)		
Describe how the intervention is culturally and linguistically appropriate.	Information is offered in Spanish. When a Member outreaches to Customer Service, additional languages are available.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Identify eligible population.		
	2. Collaborate with UnitedHealthcare team to ensure marketing materials and in-home testing kits are acceptable.		
	3. UnitedHealthcare team sends out A1c kits to eligible Members		
	4. UnitedHealthcare team and RMHP monitor A1c kit returns.		
	5. A1c results are sent to the Members' attributed primary care provider by UnitedHealthcare.		
Intervention Start Date	**05/01/2023**	**Intervention End Date**	**06/30/2024**

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**Member A1c Test Rate of Return**		
Numerator description (narrative)	**# of Members who received the A1c Testing Kit**		
Denominator description (narrative)	**# of Members who were eligible to receive the A1c Testing Kit**		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
07/01/2023-09/30/2023	**0**	**1,088**	**0%**
10/01/2023-12/31/2023	**10**	**1,088**	**0.92%**
01/01/2024-03/31/2024	**N/A**	**N/A**	**N/A**
04/01/2024-06/30/2024	**N/A**	**N/A**	**N/A**
If qualitative data were collected, provide a narrative summary of results below.			
For 2023, there were 1,088 Members who received a warming letter informing them of their eligibility to receive an A1c test kit in the mail. Members then had to request a test kit at that time. During 10/01/2023-12/31/2023 48 A1c test kits were dispatched. Of those, 10 were returned to the lab which resulted in a 0.92% return rate of kits dispatched. For 2024, the A1c warming letters are slated to be sent in August 2024. It should be noted, the RMHP quality team engages with this vendor during the first two quarters of the year to identify eligible Members in which to enroll in this program for the year. However, kits and letters are not deployed until quarters 3 and 4 of the year.			

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
There was a lower Rate of Return (RoR) than anticipated for this intervention. Especially given the purpose behind this intervention to complete the preventive screening in the convenience of Members' homes. The team expects that there will continue to be a need to continue to offer multiple methods of reaching members to close gaps in care in future years.
What challenges were encountered?
There was a significant update to the marketing and communication policies and protocols in 2024. This led to the delay in sending Medicaid warming letters by 1 month due to adding the appropriate logos to all Member facing materials. Additionally, the approval process that the vendor requires is cumbersome and requires multiple levels of approval and multiple people to be involved which proved to be challenging. In future years, we will plan to engage with the vendor earlier in the year to attempt to get warming letters out earlier in the summer.
How were the challenges resolved?
Even with the marketing and communication updates, RMHP was able to get the additional logos added to the Member facing materials to meet contractual requirements and still be included in the 2024 LGC program.
What successes were demonstrated through the intervention testing?
RMHP will continue this intervention. The goal is a higher Rate of Return (RoR) in 2024 as the second year offering this program to Member's to complete their annual A1c in the convenience of their homes. We believe that a combination of at home testing and offering programs like incentives will lead to the greatest amount of gap closure opportunities.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Performance Improvement Projects

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon X Continue
Rationale for Intervention Status Selected
This was a new intervention in 2023. Our goal is to see a high participation and Rate of Return (RoR) in 2024 since this will be the second year offering this program to Members to complete their annual A1c in the convenience of their own home. This intervention eliminates the barrier of transportation to their care provider's office to complete annual A1c testing. For this reason, RMHP will continue this intervention.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan Prime
PIP Title	*Diabetes A1c Poor Control for PRIME MCE Members*
Intervention Title	Primary Care Value Based Payment Program

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Performance Improvement Projects

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	**Primary Care Value Based Payment Program**		
What barrier(s) are addressed?	Coding education and processes Clinical workflows that support reducing A1c lab values		
Describe how the intervention is culturally and linguistically appropriate.	RMHP's provider education includes language and cultural considerations.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Identify PRIME Value Based Payment Primary Care Practices		
	2. RMHP sets a Diabetes A1c Poor Control CMS Core Measure NQF 0059 target for the PRIME practices to achieve annually as a PRIME Region.		
	3. RMHP Clinical Program Managers create educational materials and distribute to eligible practices.		
	4. Practice-level and PRIME Region data is assessed quarterly with annual evaluation.		
	5. Based on the data or expressed interest from a practice, Clinical Program Managers are deployed to assist improving coding and/or clinical workflows.		
	6. If the PRIME Region achieves the annual target, an incentive payment will be distributed to the eligible practices.		
Intervention Start Date	**01/01/2023**	**Intervention End Date**	**6/30/2024**

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**PRIME Primary Care Practice Diabetes A1c Poor Control Performance**		
Numerator description (narrative)	**# of primary care practices that achieved the RMHP Target**		
Denominator description (narrative)	**# of primary care practices enrolled in the value-based payment program**		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
01/01/2023-12/31/2023	**28**	**47**	**59.57%**
01/01/2024-12/31/2024			
01/01/2025-12/31/2025			
01/01/2026-12/31/2026			
If qualitative data were collected, provide a narrative summary of results below.			
Practices were asked to submit clinical workflows for CMS 122 Diabetes: A1c Poor Control. This enables Clinical Program Managers (CPMs) to review the workflows and better understand the practice's processes. Better understanding of the processes permits more informed conversations with the practices on how to adjust workflows to identify gaps in care and improve documentation of patient care.			

***Appendix A1-3*: State of Colorado PIP Intervention Worksheet**
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
1. CPTII coding is new for most practices and many do not understand how these codes can be beneficial for their practice. This requires education, involving members of the practices that may not historically been involved in QI work, and new workflows for the practices. 2. The largest FQHCs are not performing well as it pertains to utilizing CPT II codes, often due to coding restrictions per there approved fee schedule. Even though CPT II codes are non-reimbursable, there are limitations to how they can be utilized in terms of both types of practice and how the electronic health record sends the claim to payers.
What challenges were encountered?
1. CPTII coding in practices is an ongoing challenge. CPTII codes are informational codes and are not eligible for reimbursement. Practices do not see the benefit to them to adjust their workflows and include the CPTII codes and not receive reimbursement. The team focuses education around establishing automated processes that add CPT II codes to the most commonly used services such as Diabetes A1c tests so that it doesn't feel like an added step, but rather it is automatically added during a visit. 2. FQHCs have different billing procedures, depending on the service provided. FQHCs are concerned about including CPTII codes on the claim and having the claim rejected. Workflows continue to be challenging with these practices due to there unique fee schedules and limited billing structures. 3. RHCs are also concerned that attaching CPTII codes to a claim will deny the entire claim.
How were the challenges resolved?
1. The issue is not yet resolved, but education is being provided to practices. Practices are provided with CPTII coding guidance documents. The Diabetes A1c measure has been reviewed within the CQI Newsroom, along with coding discussions. The documents are reviewed by Clinical Program Measures (CPMs) during quality meetings with practices. 2. There is a plan to send member gap lists to practices that include both open and closed gaps, so practices can review how a member's gap was closed to align their workflows. 3. We are working with partner organizations to help with coding training for practices.
What successes were demonstrated through the intervention testing?

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
1. Practices are open to adjusting workflows to improve patient care processes. Though we have received concerns from practices around CPTII codes, practices are utilizing resources provided to them to examine their billing practices.
2. We have identified new reporting resources that can help practices examine their CPTII billing processes.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon X Continue
Rationale for Intervention Status Selected
Diabetes management is an ongoing population health concern. In 2021, diabetes was the eighth leading cause of death and accounted for $412.9 billion in healthcare costs in 2022. While our rates for this measure are improving, there is still room for improvement. Diabetes is one of the most prevalent conditions across RMHP's population per our most recent population health assessment.

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan Prime
PIP Title	*Improving Rates of Screening for Social Determinants of Health (SDOH) in PRIME Members*
Intervention Title	Payment for SDOH Screening

Appendix A1-4: State of Colorado PIP Intervention Worksheet

Improving Rates of Screening for SDOH in PRIME Members

for Rocky Mountain Health Plan Prime

Instructions: Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	**Payment for SDOH Screening**
What barrier(s) are addressed?	• After the Accountable Healthcare Communities Model (AHCM) program ended in 2022, the use of the AHCM tool for screenings generally declined across the region. Providers are less likely to complete routine screenings when they are not reimbursed for the work. • There is not a specific code for screening for SDOH linked to reimbursement, like there is with depression screenings. Some providers use Z codes to capture information about their patients' SDoH status, but those are not linked to reimbursement. For that reason, RMHP will rely upon encounter data from our data management partners, rather than setting up a new code, to track screeners eligible for reimbursement.
Describe how the intervention is culturally and linguistically appropriate.	Many of the most vulnerable members identify as being part of a marginalized cultural group, and they experience a higher likelihood of challenges with SDoH like access to food, physical safety, and housing stability. We want to ensure that SDoH impacting these vulnerable individuals' experiences within healthcare and their health outcomes are identified and addressed. We are opening this payment opportunity to both physical and behavioral health providers, recognizing that individuals have a choice where they seek healthcare services.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Research the amount currently reimbursed for depression screening and set the rate for SDOH screening.
	2. Create an internal policy and procedure for reimbursing providers for SDoH screening and tracking payments.
	3. Administer payments to providers.

Appendix A1-4: State of Colorado PIP Intervention Worksheet

Improving Rates of Screening for SDOH in PRIME Members

for Rocky Mountain Health Plan Prime

Intervention Description			
	4. Coordinate with data management partners to ensure we are receiving screening results from all eligible providers.		
	5. Offer tailored coaching to providers as needed to improve implementation, leveraging supports within QHN and RMHP's Clinical Quality Improvement department.		
Intervention Start Date (MM/DD/YYYY)	10/31/2023	**Intervention End Date (MM/DD/YYYY)**	6/30/2024

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	SDoH Screening Reimbursements		
Numerator description (narrative)	Number of reimbursed SDoH screenings as identified through encounter data		
Denominator description (narrative)	Total number of all members in PRIME		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
01/01/2024 – 03/31/2024	**Not calculated/TBD**	**Not calculated/TBD**	**Not calculated/TBD**
04/01/2024 – 06/30/2024	**Not calculated/TBD**	**Not calculated/TBD**	**Not calculated/TBD**
If qualitative data were collected, provide a narrative summary of results below.			
As outlined in the Baseline PIP submission, one of the key interventions to enhance SDoH screening rates involved reimbursing providers for completing screeners. RMHP planned to establish an internal policy and procedure to facilitate this reimbursement and track payments effectively. There was a delay in the establishment of the payment methodology and it did not go into effect until May 1, 2024. According to the payment methodology, reimbursements will be calculated and paid out annually at the end of the calendar year. Therefore, at the time of this Remeasurement Year 1 PIP submission, reimbursements have not yet been calculated or paid out to providers. Payments for SDoH screeners completed in CY2024 will be disbursed in January 2025.			

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
The results for this particular intervention's effectiveness have not been calculated or evaluated at this point, given the timelines of the reimbursement payouts.
What challenges were encountered?
There was a delay in establishing the reimbursement methodology, which was a core intervention in this PIP. This delay was partly due to the need to narrow the scope of the payment methodology based on available resources and considerations of efficiency and sustainability. Additionally, building the infrastructure to capture new Social Determinants of Health (SDoH) screeners through our data management partners' platforms and integrating this data into a reportable tool for RMHP presented further challenges.
How were the challenges resolved?
The challenges were addressed by implementing an annual payment methodology designed with the intention to ensure efficient resource utilization and by developing a sustainable technological infrastructure. Additionally, the team sought to implement strategies that would not put unnecessary burden or timely administrative tasks onto providers in which to capture and send the data elements being requested as part of this design.
What successes were demonstrated through the intervention testing?
The infrastructure to ingest and track new SDoH screeners was built, and the payment methodology was established. Many providers were able to continue their existing workflows for completing SDoH screeners that were established during the AHCM project, which contributed to some success in the screening rates. Additionally, we were able to onboard a handful of new providers whose data had not previously been captured and therefore contributing to the regional performance rate.

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon X Continue
Rationale for Intervention Status Selected
Given the delay in the establishment of RMHP's payment methodology and, simultaneously the building of technological infrastructure to support new SDoH screeners, this intervention has not been fully tested; with the payment methodology and infrastructure now in place, RMHP plans to continue the intervention for this next Remeasurement year.

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan Prime
PIP Title	*Improving Rates of Screening for Social Determinants of Health (SDOH) in PRIME Members*
Intervention Title	Provider Coaching

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Instructions: Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	**Provider Coaching**
What barrier(s) are addressed?	• Workforce Barriers: Practices are still experiencing significant provider and staff turnover which impacts the ability to adopt and sustain workflows that support SDoH screenings. Clinical Program Managers therefore spend time re-training when and where appropriate. • Complex Workflows: Practices report that screening for SDoH and implementing interventions to support patients with identified needs involves complex workflows. Staff require support in knowing how to discuss this effectively and compassionately with patients. • Technology Barriers: Data management systems are complex to navigate.
Describe how the intervention is culturally and linguistically appropriate.	RMHP's Quality Improvement Team and our data management partners have long-standing relationships with providers across RAE Region 1, including those from rural and frontier counties. We are familiar with the uniqueness of agricultural communities, and we consistently challenge ourselves to remain sensitive to the concerns and needs of rural communities. This effort also aims to reduce the burden and uncertainty that practices may experience, recognizing the immense about of burnout that healthcare workers are experiencing.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Determine a process for offering support to providers and their staff to support screening for social determinants of health. Consider specific roles for RMHP's Clinical Quality Improvement (CQI) department and our data management partners.
	2. Use data and provider requests to identify providers most in need of tailored coaching support to improve SDoH screening.

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Description			
	3. Deliver coaching as needed to our providers and their practices. This is done virtually as well as in-person.		
Intervention Start Date (MM/DD/YYYY)	1/1/2024	**Intervention End Date (MM/DD/YYYY)**	6/30/2024

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	SDoH Screening Rates		
Numerator description (narrative)	Number of unique members with a completed SDoH screener in the measurement period		
Denominator description (narrative)	Number of enrollees in PRIME during the measurement year who had at least one billed encounter in the measurement period		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
01/01/2024 – 03/31/2024	900	26,416	3.41%
04/01/2024 – 06/30/2024	869	24,126	3.60%
If qualitative data were collected, provide a narrative summary of results below.			
As a component of our annual tiering process, practices are asked a series of questions related to their competencies and workflows in social determinants of health screening practices. This process occurs each year in March to assess their status and determine a Tier level of 1 through 4. RAE Tier 1 – Tier 3 practices are eligible to earn points as part of the annual tier renewal process by screening patients for SDoH, reviewing the data that is collected from the tool, connecting patients to community resources and ensuring their care plan includes patients' social constraints. This data is reviewed by the practices assigned clinical program manager (CPM). If the practice would like to implement screening workflows, or requests additional resources, the CPM will support their practice in working to develop and implement a SDoH screening process. All Tier 1 – Tier 3 practices, approximately 66% of our practices, receive quarterly meetings to review data and to provide updates. During these meetings practices are also offered support and assistance around SDoH screening by their Clinical Program Manager			

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Effectiveness Measure
(CPM). We offer support for workflows and processes related to SDoH screening to all our practices. This coaching is provided ad hoc during in-person or virtual meetings, and we do not track its utilization internally. Practices respond better when they can ask questions and receive support during our visits, rather than scheduling separate meetings. Our support is offered virtually or in-person. We also have a CPM – Behavioral Health team members who meets with practices in-person and virtually as well to offer support around integrated behavioral health. She also providers coaching and support around workflows, processes and resources related to SDoH. We have 80/120 (65%) of our Tier 1 – Tier 3 practices who screen for Sodhi. All our Tier 1 – Tier 3 practices, approximately 66%, of them complete and submit an annual attestation asking them about their screening process. The following questions are asked: • Does your practice routinely assess patients' psychosocial needs using a validated screening tool (AHCM, Health Leads, PRAPARE, SEEK, Colorado Children's Hospital Social Needs Tool) • Does your practice review data collected from a standardized screening tool • Does your practice connect patients who screen positive for a social need with community resources • Does your practice ensure that care plans created for patients account for patient social constraints, what SDoH screening tool does your practice primarily use? We are then able to use the data above to then inform practices who are not screening that we are offering reimbursement for SDoH screening as well as discussing the value of screening and offering support. If they are screening, we still offer support to ensure they have a sustainable process.

***Appendix A1-5*: State of Colorado PIP Intervention Worksheet**
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
Practices require flexibility as it pertains to how data flows and is communicated to the RAE for tracking and triggering payment.
What challenges were encountered?
During the 6-month intervention period the CQI Department experienced the loss of key staff who were responsible for supporting providers and practice coaching. This created a challenge to offering support to providers and their staff for SDoH screening. Some practices are working through technology related barriers that impact the flow of data between their EHR and the RAE. This required some technical assistance by both RMHP and the local Health Information Exchange (QHN) which is how we are leveraging the flow of this data for tracking purposes.
How were the challenges resolved?
Challenges have been resolved as a new key staff member has been hired in the QI Department and is trained to support providers for SDoH screening. RMHP and QHN are collaborating with providers where assistance is needed in establishing data flow processes to capture SDoH screening results.
What successes were demonstrated through the intervention testing?
RMHP worked with both primary care and pediatric practices to stand up new processes with QHN to ensure appropriate flow of SDoH screening results to the RAE (to include PRIME). The CQI Department does track data on SDoH screening for all Tier 1 – Tier 3 practices in RAE Region 1. The following questions are asked of practices in RAE Region 1:

2023 Team-based Care: Behavioral Health and Psychosocial Needs							
Question	**No Response**		**Yes**		**No**		**Total**
	Count	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Evaluation Results							
Does your practice routinely assess patients' psychosocial needs using a validated screening tool (AHCM, Health Leads, PRAPARE, SEEK, Colorado Children's Hospital Social Needs Tool)?	29	36.25%	38	47.50%	13	16.25%	80
Does your practice review data collected from a standardized screening tool?	30	37.50%	41	51.25%	9	11.25%	80
Does your practice connect patients who screen positive for a social need with community resources?	31	38.75%	45	56.25%	4	5.00%	80
Does your practice ensure that care plans created for patients account for patient social constraints?	32	40.00%	39	48.75%	9	11.25%	80

Appendix A1-5: State of Colorado PIP Intervention Worksheet
Improving Rates of Screening for SDOH in PRIME Members
for Rocky Mountain Health Plan Prime

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon X Continue
Rationale for Intervention Status Selected
Screening processes in practices are still being implemented across RAE Region 1. While we have seen improvements in overall rates, barriers continue to impact the ability for practices to fully sustain these workflows in an effective and efficient manner. Technical Assistance from Clinical Program Managers is still required to assist with implementing screening processes.

Appendix B. Final PIP Validation Tools

Appendix B contains the final PIP Validation Tools provided by HSAG.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Demographic Information			
MCO Name:	Rocky Mountain Health Plan Prime		
Project Leader Name:	Kim Herek	**Title:**	Quality Improvement Director
Telephone Number:	402-917-1833	**Email Address:**	Kimberly.herek@uhc.com
PIP Title:	*Diabetes A1c Poor Control for PRIME MCE Members*		
Submission Date:	October 31, 2024		
Resubmission Date:	December 20, 2024		

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring.	C*	*Met*	**General Feedback:** The health plan specified "leveraging member rewards programs, at home A1c testing kits, and primary care provider value-based contract requirements" in the Aim statement. HSAG recommends using more general language such as, "targeted interventions" in the Aim statement to allow for interventions to be determined and revised throughout the duration of the PIP. If the health plan decides to use a different type of intervention, the Aim statement may need to be revised for future submissions.
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [N/A]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*N/A*	
2. Included the sample size for each indicator.	C*	*N/A*	
3. Included the margin of error and confidence level for each indicator.		*N/A*	
4. Described the method used to select the sample.		*N/A*	
5. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	5	2	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*N/A*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	1	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Rocky Mountain Health Plan Prime 2024-25 PIP Validation Tool
State of Colorado

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Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	7	3	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	The health plan reported accurate baseline and Remeasurement 1 indicator data; however, the health plan reported statistical testing results for Remeasurement 1 based on a t-test. The health plan should re-calculate statistical testing results using an appropriate two-tailed statistical test (Fisher's exact of Chi-square test) for comparing the remeasurement results to the baseline indicator results and update the statistical testing documentation in Step 7. Using a two-tailed Chi-square test with Yates correction to compare Remeasurement 1 to baseline, HSAG calculated a result of $p < 0.0001$. **Resubmission January 2025:** The health plan revised the statistical testing results reported for Remeasurement 1 and addressed the initial feedback. The validation score for this evaluation element was changed to *Met* with General Feedback. **General Feedback:** While the health plan reported $p = 0.0001$ for the revised statistical testing results, the less than sign should be used to more accurately report the p value ($p < 0.0001$).
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	**General Feedback:** Regarding the anticipated Remeasurement 1 data update, the health plan should update the Remeasurement 1 indicator results prior to the resubmission due date (1/22/2025), if possible, so that updated indicator results can be included for this year's validation. The health plan must also update the statistical testing results to align with the updated data for each indicator. **Resubmission January 2025:** The health plan updated the Remeasurement 1 data and addressed the General Feedback.
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Appendix B: State of Colorado 2024-25 PIP Validation Tool
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Results for Step 7			
Total Evaluation Elements**	3	1	Critical Elements***
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Met*	**General Comment:** The health plan should consider testing interventions for the shortest time necessary to collect meaningful effectiveness measure data and determine next steps. If a decision to adopt, adapt, or abandon can be made in three months or less, the health plan should decide on next steps and adapt the intervention or start a new intervention.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	
Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
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Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
Met	8	4	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Met*	
2. There was improvement over baseline performance across all performance indicators.		*Met*	
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Met*	
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.

Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

Table B—1 2024-25 PIP Validation Tool Scores
for *Diabetes A1c Poor Control for PRIME MCE Members* for Rocky Mountain Health Plan Prime

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	1	0	0	1	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	3	0	0	0	1	1	0	0	0
Totals for All Steps	**26**	**18**	**0**	**0**	**7**	**13**	**10**	**0**	**0**	**3**

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Diabetes A1c Poor Control for PRIME MCE Members* for Rocky Mountain Health Plan Prime	
Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Diabetes A1c Poor Control for PRIME MCE Members* for Rocky Mountain Health Plan Prime	
Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not 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.*
*** Confidence Level: See confidence level definitions on next page.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Diabetes A1c Poor Control for PRIME MCE Members
for Rocky Mountain Health Plan Prime

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
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*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. 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.
Confidence Level for Significant Improvement:	***High Confidence***

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Improving the Rate of SDOH Screening for PRIME Members
for Rocky Mountain Health Plan Prime

Demographic Information			
MCO Name:	Rocky Mountain Health Plan Prime		
Project Leader Name:	Kimberly Herek	**Title:**	Director of Quality Improvement
Telephone Number:	Not Applicable	**Email Address:**	Kimberly.Herek@uhc.com
PIP Title:	*Improving the Rate of Social Determinants of Health (SDOH) Screening for PRIME Members*		
Submission Date:	October 31, 2024		
Resubmission Date:	December 20, 2024		

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [N/A]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*N/A*	
2. Included the sample size for each indicator.	C*	*N/A*	
3. Included the margin of error and confidence level for each indicator.		*N/A*	
4. Described the method used to select the sample.		*N/A*	
5. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	5	2	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
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*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements*****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	1	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	8	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	6	3	*N/A (Not Applicable)*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	The health plan reported accurate baseline and Remeasurement 1 numerators, denominators, and percentages; however, the health plan reported statistical testing results for Remeasurement 1 based on a t-test. The health plan should re-calculate and report results from an appropriate two-tailed statistical test (Fisher's exact or Chi-square test) for comparing the remeasurement results to baseline indicator results. Using a two-tailed Chi-square test with Yates correction to compare Remeasurement 1 to baseline, HSAG calculated a result of $p < 0.0001$. HSAG is available to provide statistical testing support and technical assistance upon request, if needed. **Resubmission January 2025:** The health plan corrected the statistical testing and accurately reported the results. The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	The health plan should revise the Baseline to Remeasurement 1 Narrative after re-calculating the comparison of Remeasurement 1 to baseline results using an appropriate two-tailed statistical test (Fisher's exact or Chi-square test), as noted in the feedback for Evaluation Element 1, above. In addition, when describing the difference between the baseline and Remeasurement 1 indicator rates, the correct units is percentage points, rather than percent. **Resubmission January 2025:** The health plan corrected the statistical testing and accurately reported the results in the Remeasurement 1 Narrative. The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

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Results for Step 7			
Total Evaluation Elements**	3	1	Critical Elements***
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Met*	HSAG identified the following opportunities for improvement: •For the Provider Coaching intervention, the health plan should include more detail in the intervention process steps to illustrate the content of provider coaching and how coaching was delivered (one-on-one versus group; in-person, virtual, phone call, etc.) •For the Provider Coaching intervention, the health plan reported quarterly data for the overall performance indicator for the Intervention Effectiveness Measure. The Intervention Effectiveness Measure should be specific to the intervention. The health plan should report data specific to the provider coaching activities that occurred from 1/1/2024 through 6/30/2024. For example, the percentage of providers targeted for coaching who were successfully reached and received coaching and/or the percentage of members assigned to providers who received coaching who completed a SDOH screening. •In addition, for the Provider Payments intervention, the health plan should consider collecting more real-time, process-level intervention effectiveness data to support timely decisions about adopting, adapting, or abandoning interventions to support overall improvement in performance indicator results. **Resubmission January 2025:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	

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Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
Met	8	4	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Met*	
2. There was improvement over baseline performance across all performance indicators.		*Not Met*	There was a decline in indicator results from baseline to Remeasurement 1. **Resubmission January 2025:** The indicator results remained the same; therefore, the validation score for this evaluation element remains *Not Met*.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Met*	There was a decline in indicator results from baseline to Remeasurement 1. **Resubmission January 2025:** The indicator results remained the same; therefore, the validation score for this evaluation element remains *Not Met*.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	2	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Table B—1 2024-25 PIP Validation Tool Scores for *Improving the Rate of SDOH Screening for PRIME Members* for Rocky Mountain Health Plan Prime										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *N/A***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *N/A***
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	1	0	2	0	1	1	0	0	0
Totals for All Steps	**26**	**17**	**0**	**2**	**6**	**13**	**10**	**0**	**0**	**3**

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Improving the Rate of SDOH Screening for PRIME Members* for Rocky Mountain Health Plan Prime	
Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Improving the Rate of SDOH Screening for PRIME Members* for Rocky Mountain Health Plan Prime	
Percentage Score of Evaluation Elements *Met**	***33%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***No Confidence***

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not 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.*
*** Confidence Level: See confidence level definitions on next page.

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EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
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*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. 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.
Confidence Level for Significant Improvement:	***No Confidence***