



**COLORADO**

**Department of Health Care  
Policy & Financing**

Regional Accountable Entities (RAEs)  
for the Colorado Accountable Care Collaborative

**Fiscal Year 2024–2025 PIP Validation Report**  
*for*  
**Rocky Mountain Health Plan Region 1**

*April 2025*

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





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## Acknowledgements and Copyrights

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## 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 Regional Accountable Entities (RAEs) to conduct and submit performance improvement projects (PIPs) annually for validation by the State's external quality review organization (EQRO). Rocky Mountain Health Plan Region 1, referred to in this report as RMHP R1, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid 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 R1 submitted two PIPs: *Follow-Up After Hospitalization for Mental Illness [FUH] 7-Day and 30-Day in RAE BH [Behavioral Health] Members* and *Improving the Rate of SDOH [Social Determinants of Health] Screening for RAE Members in Region 1*. 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 *FUH 7-Day and 30-Day in RAE BH Members* PIP addresses quality, timeliness, and accessibility of follow-up care and services for adult members hospitalized for treatment of mental illness. The topic, selected by RMHP R1 and approved by the Department, was supported by historical data. The PIP Aim statement is as follows: “Does leveraging provider incentives improve the 7-day and 30-day follow up rates for Members with a hospitalization due to mental illness in the RMHP RAE population?”

The nonclinical *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP addresses quality and accessibility of healthcare and services for RAE 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 Indicators
<i>FUH 7-Day and 30-Day in RAE BH Members</i>	The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.
	The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 30 days after discharge.
<i>Improving the Rate of SDOH Screening for RAE Members in Region 1</i>	The percentage of eligible members in the Accountable Care Collaborative (ACC) Program who had at least one billed encounter and who completed an SDOH screening in the measurement year.



## 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 primary care case management entities (PCCM entities). 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. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with RAEs in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

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).<sup>1</sup> 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 R1 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 RAE’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 R1 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 RAE 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 RAE during the PIP.

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<sup>1</sup> 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), RAE 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 R1's PIP Submission Form. This form provides detailed information about RMHP R1'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 RAE 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)

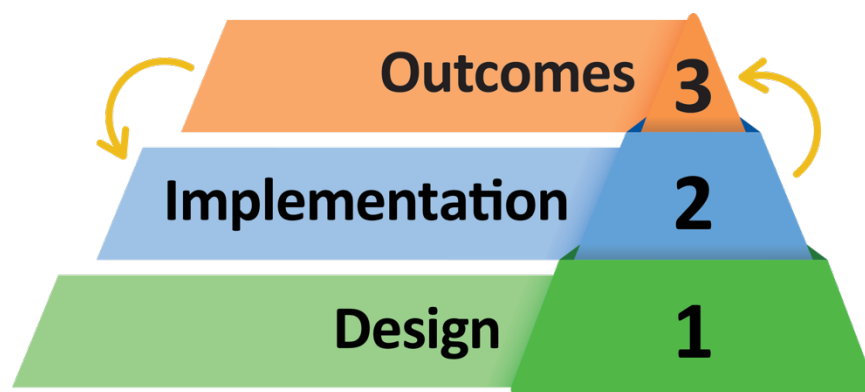
- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators 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 R1 establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, RMHP R1 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 R1 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 R1**

PIP Title	Type of Review <sup>1</sup>	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 <i>Met</i> <sup>2</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>3</sup>	Confidence Level <sup>4</sup>	Percentage Score of Evaluation Elements <i>Met</i> <sup>2</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>3</sup>	Confidence Level <sup>4</sup>
<i>FUH 7-Day and 30-Day in RAE BH Members</i>	Initial Submission	80%	78%	<i>Low Confidence</i>	67%	100%	<i>Moderate Confidence</i>
	Resubmission	93%	89%	<i>Low Confidence</i>	67%	100%	<i>Moderate Confidence</i>
<i>Improving the Rate of SDOH Screening for RAE Members in Region 1</i>	Initial Submission	81%	78%	<i>Low Confidence</i>	100%	100%	<i>High Confidence</i>
	Resubmission	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>

<sup>1</sup> **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.

<sup>2</sup> **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*).

<sup>3</sup> **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*.



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

The *FUH 7-Day and 30-Day in RAE BH Members* PIP was validated through all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *Low Confidence* level for adhering to acceptable PIP methodology. RMHP R1 received *Met* scores for 100 percent of applicable evaluation elements in the Design stage (Steps 1–6) and for 88 percent of applicable evaluation elements in the Implementation (Steps 7–8) stage of the PIP. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level that the PIP achieved significant improvement. HSAG assigned a level of *Moderate Confidence* for Validation Rating 2 because the performance indicator results demonstrated improvement in performance from baseline to the first remeasurement that was not statistically significant.

The *Improving the Rate of SDOH Screening for RAE Members in Region 1* 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 R1 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.

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 R1’s *FUH 7-Day and 30-Day in RAE BH Members* PIP.

**Table 3-2—Performance Indicator Results for the *FUH 7-Day and 30-Day in RAE BH Members* PIP**

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	N: 507	39.5%	N: 582	41.1%			
	D: 1,283		D: 1,415				



Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 30 days after discharge.	N: 789	61.5%	N: 901	63.7%			
	D: 1,283		D: 1,415				

N—Numerator D—Denominator

HSAG rounded percentages to the first decimal place.

For the baseline measurement period, RMHP R1 reported that the percentage of discharges for RAE members ages 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 39.5 percent, and the percentage of discharges who had a follow-up visit within 30 days was 61.5 percent.

For the first remeasurement period, RMHP R1 reported that the percentage of discharges for RAE members ages 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 41.1 percent, and the percentage of discharges who had a follow-up visit within 30 days was 63.7 percent.

Compared to baseline results, the Remeasurement 1 results demonstrated an increase of 1.6 percentage points in the 7-day follow-up rate, and an increase of 2.2 percentage points in the 30-day follow-up rate for eligible members. The increases in 7-day and 30-day follow-up rates were not statistically significant.

Table 3-3 displays data for RMHP R1's *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP.

**Table 3-3—Performance Indicator Results for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP**

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible members in the ACC Program who had at least one billed encounter and who completed an SDOH screening in the measurement year.	N: 2,749	5.1%	N: 3,271	6.4%			
	D: 54,361		D: 51,213				

N—Numerator D—Denominator

HSAG rounded percentages to the first decimal place.



For the baseline measurement period, RMHP R1 reported that 5.1 percent of eligible RAE members who had at least one billed encounter were screened for SDOH during the measurement year.

For the first remeasurement period, RMHP R1 reported that 6.4 percent of eligible RAE 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 statistically significant increase in the percentage of eligible members screened for SDOH of 1.3 percentage points.



## 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 R1'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 RMHP R1 for the *FUH 7-Day and 30-Day in RAE BH Members* PIP.

**Table 3-4—Barriers and Interventions for the *FUH 7-Day and 30-Day in RAE BH Members* PIP**

Barriers	Interventions
<ul style="list-style-type: none"> <li>Lack of access to timely BH visits</li> <li>Lack of care coordination activities</li> </ul>	Behavioral Health Provider Incentive Program

Table 3-5 displays the barriers and interventions documented by RMHP R1 for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP.

**Table 3-5—Barriers and Interventions for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP**

Barriers	Interventions
<ul style="list-style-type: none"> <li>Less engagement from providers when work is not reimbursed.</li> <li>No code specifically set to reimburse screening for SDOH</li> </ul>	Provider payment for SDOH screening of members
<ul style="list-style-type: none"> <li>High rates of staff turnover require periodic re-training.</li> <li>SDOH screening and intervening appropriately can lead to cumbersome workflows.</li> <li>Meaningful storage of SDOH data and communication of information across care teams</li> </ul>	Provider coaching on effective and efficient SDOH screening practices



## 4. Conclusions and Recommendations



### Conclusions

For this year's validation cycle, RMHP R1 submitted the clinical *FUH 7-Day and 30-Day in RAE BH Members* PIP and the nonclinical *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP. RMHP R1 reported Remeasurement 1 performance indicator results for both PIPs and both PIPs were validated through Step 9 (Outcomes stage). The *FUH 7-Day and 30-Day in RAE BH Members* PIP received a *Low Confidence* level and the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages. In the Outcomes stage, the *FUH 7-Day and 30-Day in RAE BH Members* PIP received a *Moderate Confidence* level that the PIP achieved significant improvement and the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP received a *High 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 R1 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 R1 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs; however, the health plan received a *Partially Met* score in Step 7 for the *FUH 7-Day and 30-Day in RAE BH Members* PIP due to errors in statistical testing. In the Outcomes stage (Step 9), Remeasurement 1 results for the *FUH 7-Day and 30-Day in RAE BH Members* PIP demonstrated improvement that was not statistically significant. Remeasurement 1 results for the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP demonstrated statistically significant improvement over baseline results. RMHP R1 will report Remeasurement 2 indicator results for both PIPs and will progress to being evaluated for sustaining significant improvement for one PIP, *Improving the Rate of SDOH Screening for RAE Members in Region 1*, in next year's validation.



### Recommendations

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

- Review statistical testing procedures and ensure that statistical test results comparing performance indicator results for each remeasurement period to baseline results are accurately reported throughout the submission form for each PIP.
- 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 RAE 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 that RMHP R1 submitted to HSAG 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 submission.





**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
**FUH 7-Day and 30-Day Follow-Up in RAE BH Members**  
**for Rocky Mountain Health Plan (RAE 1)**



Demographic Information	
Managed Care Organization (MCO) Name: <u>Rocky Mountain Health Plan (RAE 1)</u>	
Project Leader Name: <u>Kim Herek</u>	Title: <u>Quality Improvement Director</u>
Telephone Number: <u>402-917-1833</u>	Email Address: <u>Kimberly.herek@uhc.com</u>
PIP Title: <u>Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow-Up)</u>	
Submission Date: <u>10/31/2023</u>	
Resubmission Date (if applicable): <u>1/22/2025</u>	





**Appendix A: State of Colorado 2024-25 PIP Submission Form  
FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
for Rocky Mountain Health Plan (RAE 1)**



**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:**

Follow-up after hospitalization for mental illness (7 day and 30 day follow up) in RAE BH Members - CMS Core Measure FUH-AD

**Provide plan-specific data:**

For 7/1/2022-6/30/2023, the FUH-AD 7-day rate for RAE Members was 39.52% using administrative claims data. The most recent 90<sup>th</sup> HEDIS national benchmark available (MY2021) was 60.58%. The FUH-AD 30-day rate was 61.50% using administrative claims data. The most recent 90<sup>th</sup> HEDIS national benchmark available (MY2021) was 72.01%. RMHP has consistently performed at the 25<sup>th</sup> percentile benchmark over the last several years when evaluating RMHP performance to the NCQA benchmark. Due to performing below benchmark, this provides opportunity to improve on the 7-day and 30-day rates.

**Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:**

By improving performance on FUH-AD, it supports improving member health and satisfaction in the following ways:

- Fostering and/or strengthening relationships between the Member who had a hospitalization for mental illness and behavioral health providers. This improves member satisfaction and patient activation.
- Providing transitions of care support, which can reduce the likelihood of readmissions and improve Member health and experience during a vulnerable time.
- Accelerating, altering and/or sustaining Member treatment plans that were established during the inpatient stay, which will improve Member health outcomes.





**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
**FUH 7-Day and 30-Day Follow-Up in RAE BH Members**  
**for Rocky Mountain Health Plan (RAE 1)**



**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 provider incentives improve the 7-day and 30-day follow up rates for Members with a hospitalization due to mental illness in the RMHP RAE population?





**Appendix A: State of Colorado 2024-25 PIP Submission Form  
FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
for Rocky Mountain Health Plan (RAE 1)**



**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:**

RAE Members ages 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 and 30 days after discharge.

**Enrollment requirements (if applicable):**

No allowable gaps in the continuous enrollment period

**Member age criteria (if applicable):**

Age 18 and older as of date of discharge

**Inclusion, exclusion, and diagnosis criteria:**

Event/diagnosis:

- An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.
- The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.





**Appendix A: State of Colorado 2024-25 PIP Submission Form  
FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
for Rocky Mountain Health Plan (RAE 1)**



**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.

**Acute readmission or direct transfer:**

- Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm, count only the last discharge.
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.

**Nonacute readmission or direct transfer:**

- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.

**Exclusions:** Beneficiaries in hospice or using hospice services anytime during the measurement year

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

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

- 2.16.840.1.113883.3.464.1004.1761
- 2.16.840.1.113883.3.464.1004.1762





**Appendix A: State of Colorado 2024-25 PIP Submission Form  
FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
for Rocky Mountain Health Plan (RAE 1)**



**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.

- 2.16.840.1.113883.3.464.1004.1395
- 2.16.840.1.113883.3.464.1004.1468
- 2.16.840.1.113883.3.464.1004.1178
- 2.16.840.1.113883.3.464.1004.1179
- 2.16.840.1.113883.3.464.1004.1398



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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.



**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
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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.”

<b>Indicator 1</b>	<b>Follow-up after hospitalization for mental illness – 7-day (CMS Core Measure FUH-AD)</b>
	<b>The CMS Core Measure FUH AD – NQF 0576 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.</b>
<b>Numerator Description:</b>	A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
<b>Denominator Description:</b>	RAE beneficiaries aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.
<b>Baseline Measurement Period</b>	07/1/2022 to 06/30/2023 using 2023 CMS Core Measure Technical Specifications
<b>Remeasurement 1 Period</b>	07/1/2023 to 06/30/2024 using 2024 CMS Core Measure Technical Specifications
<b>Remeasurement 2 Period</b>	07/1/2024 to 06/30/2025 using 2025 CMS Core Measure Technical Specifications
<b>Mandated Goal/Target, if applicable</b>	N/A



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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.”

<b>Indicator 2</b>	<b>Follow-up after hospitalization for mental illness – 30-day (CMS Core Measure FUH-AD, NQF #0576)</b>
	<b>The CMS Core Measure FUH AD – NQF 0576 was selected because it is a nationally developed and recognized measure. CMS states that the Adult Core Set includes quality measures that assesses 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.</b>
<b>Numerator Description:</b>	A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
<b>Denominator Description:</b>	RAE beneficiaries aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.
<b>Baseline Measurement Period</b>	07/1/2022 to 06/30/2023 using 2023 CMS Core Measure Technical Specifications
<b>Remeasurement 1 Period</b>	07/1/2023 to 06/30/2024 using 2024 CMS Core Measure Technical Specifications
<b>Remeasurement 2 Period</b>	07/1/2024 to 06/30/2025 using 2025 CMS Core Measure Technical Specifications





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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."

<b>Mandated Goal/Target, if applicable</b>	N/A
<b>Use this area to provide additional information.</b>	





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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)**

<p><input type="checkbox"/> Manual Data</p> <p>Data Source</p> <p><input type="checkbox"/> Paper medical record abstraction</p> <p><input type="checkbox"/> Electronic health record abstraction</p> <p>Record Type</p> <p><input type="checkbox"/> Outpatient</p> <p><input type="checkbox"/> Inpatient</p> <p><input type="checkbox"/> Other, please explain in narrative section.</p> <p><input type="checkbox"/> Data collection tool attached (required for manual record review)</p>	<p><input checked="" type="checkbox"/> Administrative Data</p> <p>Data Source</p> <p><input checked="" type="checkbox"/> Programmed pull from claims/encounters</p> <p><input type="checkbox"/> Supplemental data</p> <p><input type="checkbox"/> Electronic health record query</p> <p><input type="checkbox"/> Complaint/appeal</p> <p><input type="checkbox"/> Pharmacy data</p> <p><input type="checkbox"/> Telephone service data/call center data</p> <p><input type="checkbox"/> Appointment/access data</p> <p><input type="checkbox"/> Delegated entity/vendor data _____</p> <p><input type="checkbox"/> Other _____</p> <p>Other Requirements</p> <p><input type="checkbox"/> Codes used to identify data elements (e.g., ICD-10, CPT codes)- <u>please attach separately</u></p> <p><input type="checkbox"/> Data completeness assessment attached</p> <p><input type="checkbox"/> Coding verification process attached</p> <p>Estimated percentage of reported administrative data completeness at the time the data are generated: 99.52% complete.</p>	<p><input type="checkbox"/> Survey Data</p> <p>Fielding Method</p> <p><input type="checkbox"/> Personal interview</p> <p><input type="checkbox"/> Mail</p> <p><input type="checkbox"/> Phone with CATI script</p> <p><input type="checkbox"/> Phone with IVR</p> <p><input type="checkbox"/> Internet</p> <p><input type="checkbox"/> Other _____</p> <p>Other Survey Requirements:</p> <p>Number of waves: _____</p> <p>Response rate: _____</p> <p>Incentives used: _____</p>
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**Appendix A: State of Colorado 2024-25 PIP Submission Form  
FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
for Rocky Mountain Health Plan (RAE 1)**

**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.

	<p>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:</p> <ol style="list-style-type: none"> <li>a. Identify the claims (both paid and IBNR) by Date of Service (DOS) and Input Date (date entered into the claims payment system)</li> <li>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)</li> <li>c. Calculate the average completeness across months by 60 and 90 days (% complete for month averaged across all months)</li> <li>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.</li> <li>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).</li> </ol>	
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FUH 7-Day and 30-Day Follow-Up in RAE BH Members  
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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: Follow-up after hospitalization for mental illness – 7-day (CMS Core Measure FUH-AD, NQF #0576)**

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and <i>p</i> Value
07/01/2022–06/30/2023	Baseline	507	1283	39.52%	N/A for baseline	N/A for baseline
07/01/2023–06/30/2024	Remeasurement 1	582	1415	41.13%	N/A	Chi-square; Two-tailed, Not Statistically Significant <i>p</i> -value = 0.5779
07/01/2024–06/30/2025	Remeasurement 2					

**Indicator 2 Title: Follow-up after hospitalization for mental illness – 30-day (CMS Core Measure FUH-AD, NQF #0576)**

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test, Statistical Significance, and <i>p</i> Value
07/01/2022–06/30/2023	Baseline	789	1283	61.50%	N/A for baseline	N/A for baseline
07/01/2023–06/30/2024	Remeasurement 1	901	1415	63.67%	N/A	Chi-square; Two-tailed, Not Statistically Significant, <i>p</i> -value = 0.5754
07/01/2024–06/30/2025	Remeasurement 2					



**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 both Indicator 1 and Indicator 2 demonstrate that only 39.52% and 61.50%, respectively, of RAE Members have a follow-up visit within the recommended timeframes of 7 and 30 days. This data analysis was conducted by using administrative claims data to identify and calculate eligible Members and the number of Members who received follow-up visits per the measure specifications. There are no identified factors that threaten internal or external validity of the findings.

**Baseline to Remeasurement 1 Narrative:** The baseline findings for both Indicator 1 and Indicator 2 demonstrate that only 41.13% and 63.67%, respectively, of RAE Members have a follow-up visit within the recommended timeframes of 7 and 30 days. This data analysis was conducted by using administrative claims data to identify and calculate eligible Members and the number of Members who received follow-up visits per the measure specifications. Performance for Indicator 1 and Indicator 2 has improved; however, neither indicator shows statistically significant improvements.

**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 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 Program Manager specializing in Integrated Behavioral Health. 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:**

Follow-up after hospitalization for mental illness is a prioritized measure for RMHP. The QI team hosts monthly meetings with Internal Quality Workgroups (IQWgs) to discuss barriers, identify improvement areas, and implement interventions for all prioritized measures. RMHP also hosts a monthly committee, the Provider Cross Collaboration Committee (PCCC), that consists of RMHP staff and external behavioral health providers and organizations from Community Mental Health Centers (CMHCs), independent behavioral health provider network (IPN), and integrated behavioral health (IBH). From the IQWg and PCCC discussions and data analysis, the QI team and senior leaders determined that a major barrier to follow up after hospitalization for mental illness pertains to unmet social determinants of health (SDoH) needs limiting the Member in getting to the appointment, Member lack of motivation or understanding of the importance of follow-up visits, behavioral health visit access (especially within 7 days), and difficulty conducting care coordination activities due to incorrect Member contact information or unstable contact information (ie. transient, limited or no cell phone minutes, etc.).



**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

**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
Behavioral Health Provider Incentive Program	<ul style="list-style-type: none"> <li>- Access to timely behavioral health visits</li> <li>- Conducting care coordination activities</li> </ul>

**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 A: State of Colorado 2024-25 PIP Submission Form**  
**Improving the Rate of SDOH Screening for RAE Members in**  
**Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



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





**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
**Improving the Rate of SDOH Screening for RAE Members in**  
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**for Rocky Mountain Health Plan (RAE 1)**



**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 RAE 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.





**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
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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?





**Appendix A: State of Colorado 2024-25 PIP Submission Form**  
**Improving the Rate of SDOH Screening for RAE Members in**  
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**for Rocky Mountain Health Plan (RAE 1)**



**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 RAE 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: All full benefit Medicaid Clients (in accordance with the State of Colorado eligibility requirements) will be mandatorily enrolled into the Accountable Care Collaborative (ACC) Program, with the exception of individuals that choose the Program of All- Inclusive Care for the Elderly (PACE); this population includes Medicaid-enrolled members assigned to RAE Region 1, according to the State's attribution methodology for SFY23- 24.

**Member age criteria (if applicable):** per State Medicaid contract

**Inclusion, exclusion, and diagnosis criteria:** all Members enrolled in the ACC program for the measurement year, in accordance with State eligibility criteria

**Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):** per State Medicaid contract





**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 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.”

<b>Indicator 1</b>	<b>SDoH Screening Rate for Unique Members in Clinical Settings</b>
	The improvement of SDoH screening rates is a mandated PIP topic for SFY25. RMHP is defining the performance indicator as screening rates for <i>unique</i> 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.
<b>Numerator Description:</b>	Number of unique members with a completed SDoH screener in the measurement year
<b>Denominator Description:</b>	Number of enrollees in the ACC during the measurement year who had at least one billed encounter in the measurement year
<b>Baseline Measurement Period</b>	07/1/2022 to 06/30/2023
<b>Remeasurement 1 Period</b>	07/01/2023 to 06/30/2024
<b>Remeasurement 2 Period</b>	07/01/2024 to 06/30/2025





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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."

<b>Mandated Goal/Target, if applicable</b>	N/A
<b>Use this area to provide additional information.</b> 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)**

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

**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 30<sup>th</sup>, 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).





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- ◆ 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.

	<p><b>Include a narrative of how claims lag may have impacted the data reported:</b> Claims data used to complete the denominator is pulled at least 120 days after the end of the measurement year, thus allowing ample time for claims lag.</p>	
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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 <i>p</i> Value
07/01/2022-06/30/2023	Baseline	2749	54,361	5.06%	N/A for baseline	N/A for baseline
07/01/2023-06/30/2024	Remeasurement 1	3271	51, 213	6.39%	N/A for RMY1	Used a Chi-square with Yates Correction statistical test; Chi squared value equals 86.519 with 1 degree of freedom; two-tailed <i>P</i> value is less than 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:** SDOH screening rates remain low at 5.06% 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 improved by 1.33%. Using a Chi-square with Yates Correction statistical test, the chi-squared value equals 86.519 with 1 degree of freedom. The two-tailed P value is less than 0.0001, which is considered to be statistically significant. This improvement could be a result of new SDOH tools being built into the data infrastructure that is reportable to RMHP; providers have been screening using various tools in recent years, but only AHCM was being ingested by RMHP. Although there was an increase, the overall results were affected by the delay in establishing the payment methodology for





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**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.

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, 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





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  - o Intervention Evaluation Results
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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.

**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	<ul style="list-style-type: none"> <li>Less engagement from providers when work is not reimbursed</li> <li>No code specifically set to reimburse screening for SDOH</li> </ul>
Provider Coaching	<ul style="list-style-type: none"> <li>High rates of staff turnover require periodic re-training</li> <li>SDOH screening and intervening appropriately can lead to cumbersome workflows</li> </ul>





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  - Intervention Evaluation Results
  - Intervention Status

- Meaningful storage of SDOH data and communication of information across care teams

**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 R1 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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan (RAE 1)
PIP Title	<i>Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow-Up)</i>
Intervention Title	Behavioral Health Provider Incentive Program



**Appendix A1-1: State of Colorado PIP Intervention Worksheet**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

**Instructions:** Complete a separate worksheet for each intervention.

Intervention Description			
<b>Intervention Title</b>	<b>Behavioral Health Provider Incentive Program</b>		
<b>What barrier(s) are addressed?</b>	Access to timely behavioral health visits Conducting care coordination activities		
<b>Describe how the intervention is culturally and linguistically appropriate.</b>	RMHP's care coordinators utilize the language line if needed, and the service is offered to network providers to assist Members.		
<b>Intervention Process Steps</b> <i>(List the step-by-step process required to carry out this intervention.)</i>	<ol style="list-style-type: none"> <li>1. Identify behavioral health providers who have capacity and are interested in participating in the program. Enrollment occurs at the practice/organization level.</li> <li>2. RMHP care coordinators refer Members needing a follow up visit to enrolled behavioral health practice.</li> <li>3. The behavioral practices outreach and schedule the Member within 7 days and then 30 days.</li> <li>4. RMHP monitors practice level performance and shares data quarterly.</li> <li>5. RMHP pays behavioral health practices annually for the number of visits completed within 7 days. The 30-day rate is not incentivized for this FY because RMHP believes if the 7 day visit is completed, then the 30 day rate will also increase because the relationship with the provider will have been established.</li> </ol>		
<b>Intervention Start Date</b>	<b>07/01/2023</b>	<b>Intervention End Date</b>	<b>06/30/2024</b>



**Appendix A1-1: State of Colorado PIP Intervention Worksheet**  
**FUH 7-Day and 30-Day Follow-Up**  
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Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	Behavioral Health Provider Incentive Program		
Numerator description (narrative)	# of behavioral health follow up visits completed within 7 days of inpatient discharge for mental illness by an enrolled behavioral health practice		
Denominator description (narrative)	# of hospitalizations for mental illness		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator	Denominator	Percentage
07/01/2023-06/30/2024	232	1454	15.90%
07/01/2024-06/30/2025			
07/01/2025-06/30/2026			
If qualitative data were collected, provide a narrative summary of results below.			
<p>A total of 23 practices participated in the BHIP incentive program FY23-24. As noted on the PIP submission form, a total of 599 follow up visits were completed within the 7-day timeframe, with a performance percentage and denominator increase from baseline data. A total of 232 of these follow up visits were completed by the providers who were incentivized to do follow up. As noted on the PIP submission form, RMHP has identified an educational opportunity for providers to learn more about measure specifications as some have reported they are providing appropriate clinical care, but services are not included in the measure specifications. RMHP has also increased the number of providers participating in the incentive program by 2 and will continue to support this incentive program in this next fiscal year.</p>			





**Appendix A1-1: State of Colorado PIP Intervention Worksheet**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



Intervention Evaluation Results
<b>What lessons did the MCO learn from the intervention testing and evaluation results?</b>
<ol style="list-style-type: none"> <li>1. Providers participating in the BHIP Incentive program are sent performance reports for program monitoring. After the first round of quarterly performance data was sent to providers, several practices notified RMHP of Members that had been seen for follow up visits that were not found on their performance data reports. This created an opportunity for providers to review their billing practices, as some that are in integrated care settings found that these visits were not documented in a manner where billing departments would be flagged to bill.</li> <li>2. Additionally, RMHP noted that quarterly performance data did not allow providers enough time to review performance and course correct any discrepancies in a timely manner. RMHP is now providing monthly performance data to these providers, so they have more time in which to implement workflow changes.</li> <li>3. Per provider reports, there are some clinically indicated services provided to members as follow up that are not a part of the measure specification, such as outreach services and other Colorado specific Behavioral Health Medicaid codes that are not included in the CMS core measure set specifications. RMHP encourages providers to continue to provide the most clinically appropriate services for quality patient care while familiarizing themselves with what clinical services meet measure specifications.</li> </ol>
<b>What challenges were encountered?</b>
As noted above, providers experienced some challenges working with measure specifications; timeliness in which to implement workflow changes after receiving feedback on their performance and following billing guidance that may or may be in direct alignment with CMS core measure set specifications. RMHP remains focused on supporting providers in implementing Member focused quality care activities that meet the intent of the measure while ensuring safe and effective best practices.
<b>How were the challenges resolved?</b>
RMHP staff is now available to review performance data with providers per request. This allows providers to identify any gaps in workflows, increase their understanding of measure specifications and keep continued focus on the need for prioritization of these follow up visits. Offering technical assistance in this manner allows us to meet practices where they are in the implementation of complex workflows such as those required within this type of measure.
<b>What successes were demonstrated through the intervention testing?</b>





**Appendix A1-1: State of Colorado PIP Intervention Worksheet**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



**Intervention Evaluation Results**

The intervention testing showed a slight but steady increase in follow up visits rates throughout the remeasurement period. Providing data and feedback to participants was successful in that it demonstrated proactive engagement by several practices who were focused on process improvement activities around workflow enhancements.





**Appendix A1-1: State of Colorado PIP Intervention Worksheet**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



Intervention Status
<b>Select one intervention status:</b> <input type="checkbox"/> Adopt <input type="checkbox"/> Adapt <input type="checkbox"/> Abandon <input checked="" type="checkbox"/> Continue
<b>Rationale for Intervention Status Selected</b>
<p>RMHP would like to continue this intervention for the next remeasurement period. Recognizing the value in incentivizing providers to prioritize follow up visits after mental health hospitalization, RMHP has added two new providers to the incentive program for this fiscal year. For continuing providers in the program, RMHP has updated contact information and believes the recent payout from previous fiscal year will be a continued motivator in program participation.</p>





**Appendix A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan (RAE 1)
PIP Title	<i>Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1</i>
Intervention Title	Payment for SDOH Screening



**Appendix A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

**Instructions:** Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	Payment for SDOH Screening
<b>What barrier(s) are addressed?</b>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>
<b>Describe how the intervention is culturally and linguistically appropriate.</b>	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.
<b>Intervention Process Steps</b> ( <i>List the step-by-step process required to carry out this intervention.</i> )	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 A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

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.		
<b>Intervention Start Date</b> (MM/DD/YYYY)	10/31/2023	<b>Intervention End Date</b> (MM/DD/YYYY)	6/30/2024



**Appendix A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Intervention Effectiveness Measure			
<b>Intervention Effectiveness Measure Title</b>	SDoH Screening Reimbursements		
<b>Numerator description (narrative)</b>	Number of reimbursed SDoH screenings as identified through encounter data		
<b>Denominator description (narrative)</b>	Total number of all members in RAE		
<b>Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Percentage</b>
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
<b>If qualitative data were collected, provide a narrative summary of results below.</b>			
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 A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Intervention Evaluation Results
<b>What lessons did the MCO learn from the intervention testing and evaluation results?</b>
The results for this particular intervention's effectiveness have not been calculated or evaluated at this point, given the timelines of the reimbursement payouts.
<b>What challenges were encountered?</b>
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.
<b>How were the challenges resolved?</b>
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.
<b>What successes were demonstrated through the intervention testing?</b>
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 A1-2: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



Intervention Status
<b>Select one intervention status:</b> <input type="checkbox"/> Adopt <input type="checkbox"/> Adapt <input type="checkbox"/> Abandon <input checked="" type="checkbox"/> Continue
<b>Rationale for Intervention Status Selected</b> 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 A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plan (RAE 1)
PIP Title	<i>Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1</i>
Intervention Title	Provider Coaching



**Appendix A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

**Instructions:** Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	Provider Coaching
<b>What barrier(s) are addressed?</b>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>Technology Barriers: Data management systems are complex to navigate.</li> </ul>
<b>Describe how the intervention is culturally and linguistically appropriate.</b>	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 amount of burnout that healthcare workers are experiencing.
<b>Intervention Process Steps</b> ( <i>List the step-by-step process required to carry out this intervention.</i> )	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.
	3. Deliver coaching as needed to our providers and their practices. This is done virtually as well as in-person.



**Appendix A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Intervention Description			
Intervention Start Date (MM/DD/YYYY)	1/1/2024	Intervention End Date (MM/DD/YYYY)	6/30/2024



**Appendix A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Intervention Effectiveness Measure			
<b>Intervention Effectiveness Measure Title</b>	SDoH Screening Rates		
<b>Numerator description (narrative)</b>	Number of unique members with a completed SDOH screener in the measurement period		
<b>Denominator description (narrative)</b>	Number of enrollees in the ACC during the measurement year who had at least one billed encounter in the measurement period		
<b>Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Percentage</b>
01/01/2024 – 03/31/2024	887	26,196	3.39%
04/01/2024 – 06/30/2024	819	25,469	3.22%
<b>If qualitative data were collected, provide a narrative summary of results below.</b>			
<p>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.</p> <p>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 (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</p>			





**Appendix A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



**Intervention Effectiveness Measure**

support around integrated behavioral health. She also provides 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 A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Intervention Evaluation Results							
<b>What lessons did the MCO learn from the intervention testing and evaluation results?</b>							
Practices require flexibility as it pertains to how data flows and is communicated to the RAE for tracking and triggering payment.							
<b>What challenges were encountered?</b>							
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.							
<b>How were the challenges resolved?</b>							
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.							
<b>What successes were demonstrated through the intervention testing?</b>							
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.  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:							
<b>2023 Team-based Care: Behavioral Health and Psychosocial Needs</b>							
Question	No Response		Yes		No		Total
	Count	Rate	Count	Rate	Count	Rate	Count



**Appendix A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

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 A1-3: State of Colorado PIP Intervention Worksheet**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



Intervention Status
<b>Select one intervention status:</b> <input type="checkbox"/> Adopt <input type="checkbox"/> Adapt <input type="checkbox"/> Abandon <input checked="" type="checkbox"/> Continue
<b>Rationale for Intervention Status Selected</b> 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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



Demographic Information			
<b>MCO Name:</b>	Rocky Mountain Health Plan (RAE 1)		
<b>Project Leader Name:</b>	Kim Herek	<b>Title:</b>	Quality Improvement Director
<b>Telephone Number:</b>	402-917-1833	<b>Email Address:</b>	<a href="mailto:Kimberly.herek@uhc.com">Kimberly.herek@uhc.com</a>
<b>PIP Title:</b>	Follow-Up After Hospitalization for Mental Illness (FUHI) in RAE BH Members (7-Day and 30-Day Follow-Up)		
<b>Submission Date:</b>	October 31, 2024		
<b>Resubmission Date:</b>	December 20, 2024		



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
1. Was selected following collection and analysis of data. N/A is not applicable to this element for scoring.	C*	Met	
<b>Results for Step 1</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



Appendix B: State of Colorado 2024-25 PIP Validation Tool  
FUH 7-Day and 30-Day Follow-Up  
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 2. Review the PIP Aim Statement(s):</b> 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. <i>N/A</i> is not applicable to this element for scoring.	C*	Met	<b>General Feedback:</b> The health plan specified "leveraging provider incentives" 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.
<b>Results for Step 2</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
<i>Met</i>	1	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
<p>* "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.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
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	
<b>Results for Step 3</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



Appendix B: State of Colorado 2024-25 PIP Validation Tool  
FUH 7-Day and 30-Day Follow-Up  
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored <i>Not Applicable [N/A]</i> ). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:</b>			
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	
<b>Results for Step 4</b>			
<b>Total Evaluation Elements**</b>	<b>5</b>	<b>2</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 5. Review the Selected Performance Indicator(s):</b> 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	
<b>Results for Step 5</b>			
<b>Total Evaluation Elements**</b>	<b>2</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 6. Review the Data Collection Procedures:</b> 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). <i>N/A is not applicable to this element for scoring.</i>		<i>Met</i>	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). <i>N/A is not applicable to this element for scoring.</i>	C*	<i>Met</i>	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	<i>N/A</i>	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		<i>Met</i>	
<b>Results for Step 6</b>			
<b>Total Evaluation Elements**</b>	<b>4</b>	<b>2</b>	<b>Critical Elements***</b>
<i>Met</i>	3	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	1	1	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			





**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



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



Appendix B: State of Colorado 2024-25 PIP Validation Tool  
FUH 7-Day and 30-Day Follow-Up  
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 7. Review Data Analysis and Interpretation of Results:</b> 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*	Partially Met	<p>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 or 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 <math>p = 0.3927</math> for Indicator 1 and <math>p = 0.4415</math>.</p> <p><b>Resubmission January 2025:</b> The health plan revised the statistical testing results and reported using an appropriate test (Chi-square); however, the reported testing results were incorrect. HSAG was unable to replicate the reported <math>p</math> value using the reported numerator and denominator for each indicator. The validation score for this evaluation element remains <i>Partially Met</i>. The health plan should correct the Remeasurement 1 statistical testing results, seeking technical assistance if needed, prior to the next annual submission.</p>
2. Included a narrative interpretation of results that addressed all requirements.		Met	<p>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 baseline and Remeasurement 1 indicator rates, the correct units is percentage points, rather than percent.</p> <p>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.</p> <p><b>Resubmission January 2025:</b> The health plan revised the narrative interpretation of results and the revised narrative addressed the required components. The validation score for this evaluation element has been changed to <i>Met</i>.</p>
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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Results for Step 7			
Total Evaluation Elements**	3	1	Critical Elements***
<i>Met</i>	2	0	<i>Met</i>
<i>Partially Met</i>	1	1	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
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	For the Behavioral Health Provider Incentive intervention effectiveness measure, the health plan used the overall performance indicator denominator and based the numerator on follow-up visits completed by a provider enrolled in the incentive program. Both the numerator and the denominator for the Intervention Effectiveness Measure should be based on providers enrolled in the incentive program so that the measure is specific to the intervention. Reporting de-identified quarterly data for the participating practices, as noted in Step 4 of the intervention process steps, is an example of appropriate quantitative effectiveness measure results for the intervention. Reporting the percentage of members referred to an enrolled practice for a follow-up visit (Step 2 in the intervention process steps) who complete the visit within seven days with the enrolled provider is also acceptable as an effectiveness measure for the intervention.  <b>Resubmission January 2025:</b> The health plan provided additional intervention-specific effectiveness data to the intervention worksheet and addressed the initial feedback. The validation score for this evaluation element has been changed to <i>Met</i> .
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		Met	
<b>Results for Step 8</b>			
<b>Total Elements**</b>	<b>5</b>	<b>3</b>	<b>Critical Elements***</b>
<i>Met</i>	5	3	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
* "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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
<i>Met</i>	7	3	<i>Met</i>
<i>Partially Met</i>	1	1	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>



Appendix B: State of Colorado 2024-25 PIP Validation Tool  
FUH 7-Day and 30-Day Follow-Up  
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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.</b>			
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.		Not Met	Using the reported numerators and denominators, HSAG determined that the improvement in indicator results from baseline to Remeasurement 1 was not statistically significant for either indicator.  <b>Resubmission January 2025:</b> The revised indicator results continued to demonstrate improvement that was not statistically significant. The validation score for this evaluation element remains <i>Not Met</i> .
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.
<b>Results for Step 9</b>			
<b>Total Evaluation Elements**</b>	<b>4</b>	<b>1</b>	<b>Critical Elements***</b>
Met	2	1	Met
Partially Met	0	0	Partially Met
Not Met	1	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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**

Table B—1 2024-25 PIP Validation Tool Scores for Follow-Up After Hospitalization for Mental Illness 7-Day and 30-Day Follow-Up for Rocky Mountain Health Plan (RAE 1)										
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	2	1	0	0	1	0	1	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	2	0	1	0	1	1	0	0	0
<b>Totals for All Steps</b>	<b>26</b>	<b>16</b>	<b>1</b>	<b>1</b>	<b>7</b>	<b>13</b>	<b>9</b>	<b>1</b>	<b>0</b>	<b>3</b>

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for Follow-Up After Hospitalization for Mental Illness 7-Day and 30-Day Follow-Up for Rocky Mountain Health Plan (RAE 1)	
Percentage Score of Evaluation Elements Met*	93%
Percentage Score of Critical Elements Met**	89%
Confidence Level***	Low Confidence

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day and 30-Day Follow-Up for Rocky Mountain Health Plan (RAE 1)	
Percentage Score of Evaluation Elements Met*	67%
Percentage Score of Critical Elements Met**	100%
Confidence Level***	Moderate 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**  
**FUH 7-Day and 30-Day Follow-Up**  
**for Rocky Mountain Health Plan (RAE 1)**



**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:**

<b>High Confidence:</b>	High confidence in reported PIP results. All critical evaluation elements were <i>Met</i> , and 90 percent to 100 percent of all evaluation elements were <i>Met</i> across all steps.
<b>Moderate Confidence:</b>	Moderate confidence in reported PIP results. All critical evaluation elements were <i>Met</i> , and 80 percent to 89 percent of all evaluation elements were <i>Met</i> across all steps.
<b>Low Confidence:</b>	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Partially Met</i> .
<b>No Confidence:</b>	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Not Met</i> .

**Confidence Level for Acceptable Methodology:** *Low 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:**

<b>High Confidence:</b>	All performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<b>Moderate Confidence:</b>	To receive <i>Moderate Confidence</i> for significant improvement, one of the three scenarios below occurred: <ol style="list-style-type: none"> <li>1. All performance indicators demonstrated improvement over the baseline, <b>and</b> some but not all performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.</li> <li>2. All performance indicators demonstrated improvement over the baseline, <b>and</b> none of the performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.</li> <li>3. Some but not all performance indicators demonstrated improvement over baseline, <b>and</b> some but not all performance indicators demonstrated <i>statistically significant</i> improvement over baseline.</li> </ol>
<b>Low Confidence:</b>	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator <b>or</b> some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<b>No Confidence:</b>	The remeasurement methodology was not the same as the baseline methodology for all performance indicators <b>or</b> none of the performance indicators demonstrated improvement over the baseline.

**Confidence Level for Significant Improvement:** *Moderate Confidence*





**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



Demographic Information			
<b>MCO Name:</b>	Rocky Mountain Health Plan (RAE 1)		
<b>Project Leader Name:</b>	Kimberly Herek	<b>Title:</b>	Director of Quality Improvement
<b>Telephone Number:</b>	Not Applicable	<b>Email Address:</b>	<a href="mailto:Kimberly.Herek@uhc.com">Kimberly.Herek@uhc.com</a>
<b>PIP Title:</b>	Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1		
<b>Submission Date:</b>	October 31, 2024		
<b>Resubmission Date:</b>	December 20, 2024		



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
1. Was selected following collection and analysis of data. N/A is not applicable to this element for scoring.	C*	Met	
<b>Results for Step 1</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 2. Review the PIP Aim Statement(s):</b> 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. <i>N/A</i> is not applicable to this element for scoring.	C*	Met	
<b>Results for Step 2</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
<i>Met</i>	1	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. <i>N/A is not applicable to this element for scoring.</i>	C*	Met	
<b>Results for Step 3</b>			
<b>Total Evaluation Elements**</b>	<b>1</b>	<b>1</b>	<b>Critical Elements***</b>
<i>Met</i>	1	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored <i>Not Applicable [N/A]</i> ). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:</b>			
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	
<b>Results for Step 4</b>			
<b>Total Evaluation Elements**</b>	<b>5</b>	<b>2</b>	<b>Critical Elements***</b>
<i>Met</i>	0	0	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	5	2	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 5. Review the Selected Performance Indicator(s):</b> 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	
<b>Results for Step 5</b>			
<b>Total Evaluation Elements**</b>	<b>2</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 6. Review the Data Collection Procedures:</b> 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). <i>N/A is not applicable to this element for scoring.</i>		<i>Met</i>	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). <i>N/A is not applicable to this element for scoring.</i>	C*	<i>Met</i>	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	<i>N/A</i>	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		<i>Met</i>	
<b>Results for Step 6</b>			
<b>Total Evaluation Elements**</b>	<b>4</b>	<b>2</b>	<b>Critical Elements***</b>
<i>Met</i>	3	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	1	1	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			





**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



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



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>Step 7. Review Data Analysis and Interpretation of Results:</b> 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	<p>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 <math>p &lt; 0.0001</math>. HSAG is available to provide statistical testing support and technical assistance upon request, if needed.</p> <p><b>Resubmission January 2025:</b> The health plan revised the statistical testing results, using an appropriate test, and addressed the initial feedback. The validation score for this evaluation element has been changed to <i>Met</i>.</p>
2. Included a narrative interpretation of results that addressed all requirements.		Met	<p>The health plan should revise the Baseline to Remeasurement 1 Narrative after recalculating 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.</p> <p><b>Resubmission January 2025:</b> The health plan revised the statistical testing results reported in the Baseline to Remeasurement 1 Narrative and addressed the initial feedback. The validation score for this evaluation element has been changed to <i>Met</i>.</p>
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**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Results for Step 7			
Total Evaluation Elements**	3	1	Critical Elements***
<i>Met</i>	3	1	<i>Met</i>
<i>Partially Met</i>	0	0	<i>Partially Met</i>
<i>Not Met</i>	0	0	<i>Not Met</i>
<i>N/A (Not Applicable)</i>	0	0	<i>N/A (Not Applicable)</i>
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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:</b>			
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	<p>HSAG identified the following opportunities for improvement:</p> <ul style="list-style-type: none"> <li>•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.)</li> <li>•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.</li> <li>•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.</li> </ul> <p><b>Resubmission January 2025:</b> The health plan revised the intervention worksheet documentation and addressed the initial feedback. The validation score for this evaluation element has been changed to <i>Met</i>.</p>
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		Met	





**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



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

\* "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**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



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



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Evaluation Elements	Critical	Scoring	Comments/Recommendations
<b>Performance Improvement Project Validation</b>			
<b>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.</b>			
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.
<b>Results for Step 9</b>			
<b>Total Evaluation Elements**</b>	<b>4</b>	<b>1</b>	<b>Critical Elements***</b>
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)
<p>* "C" in this column denotes a critical evaluation element.</p> <p>** This is the total number of all evaluation elements for this step.</p> <p>*** This is the total number of critical evaluation elements for this step.</p>			



**Appendix B: State of Colorado 2024-25 PIP Validation Tool**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**

Table B—1 2024-25 PIP Validation Tool Scores for Improving the Rate of SDOH Screening for RAE Members in Region 1 for Rocky Mountain Health Plan (RAE 1)										
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	3	0	0	0	1	1	0	0	0
<b>Totals for All Steps</b>	<b>26</b>	<b>19</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>13</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>3</b>

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 RAE Members in Region 1 for Rocky Mountain Health Plan (RAE 1)	
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 RAE Members in Region 1 for Rocky Mountain Health Plan (RAE 1)	
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**  
**Improving the Rate of SDOH Screening for RAE Members in Region 1**  
**for Rocky Mountain Health Plan (RAE 1)**



**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:

<b>High Confidence:</b>	High confidence in reported PIP results. All critical evaluation elements were <i>Met</i> , and 90 percent to 100 percent of all evaluation elements were <i>Met</i> across all steps.
<b>Moderate Confidence:</b>	Moderate confidence in reported PIP results. All critical evaluation elements were <i>Met</i> , and 80 percent to 89 percent of all evaluation elements were <i>Met</i> across all steps.
<b>Low Confidence:</b>	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Partially Met</i> .
<b>No Confidence:</b>	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Not Met</i> .

**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:

<b>High Confidence:</b>	All performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<b>Moderate Confidence:</b>	To receive <i>Moderate Confidence</i> for significant improvement, one of the three scenarios below occurred: <ol style="list-style-type: none"> <li>1. All performance indicators demonstrated improvement over the baseline, <b>and</b> some but not all performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.</li> <li>2. All performance indicators demonstrated improvement over the baseline, <b>and</b> none of the performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.</li> <li>3. Some but not all performance indicators demonstrated improvement over baseline, <b>and</b> some but not all performance indicators demonstrated <i>statistically significant</i> improvement over baseline.</li> </ol>
<b>Low Confidence:</b>	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator <b>or</b> some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<b>No Confidence:</b>	The remeasurement methodology was not the same as the baseline methodology for all performance indicators <b>or</b> none of the performance indicators demonstrated improvement over the baseline.

**Confidence Level for Significant Improvement:** *High Confidence*