COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2023–2024 PIP Validation Report

for

Rocky Mountain Health Plan Region 1

April 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Copyrights

1. Executive Summary

Pursuant to 42 CFR §457.1250, which requires states' Medicaid managed care programs to participate in external quality review (EQR), the State of Colorado, Department of Health Care Policy and Financing (the Department) required its 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 2023–2024 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
FUH 7-Day and 30-Day in RAE BH Members	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.
Improving the Rate of SDOH Screening for RAE Members in Region 1	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 Protocol 1).[1-1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that RMHP 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.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 27, 2024.

Validation Overview

For FY 2023–2024, 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 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 Protocol 1 steps:

Table 2-1—CMS Protocol 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 2023–2024 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 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*.

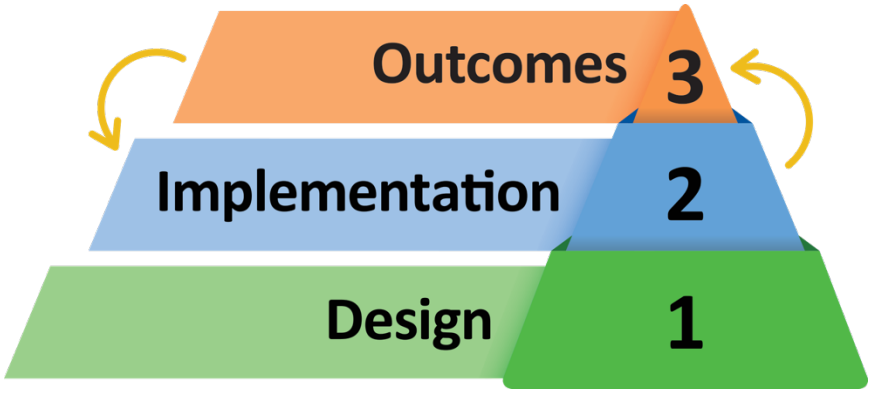
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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—i.e., 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. This stage includes data analysis and interventions. 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 is the final stage, which involves the evaluation of statistically, clinically, or programmatically 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. 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.

RMHP R1 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the *FUH 7-Day and 30-Day in RAE BH Members* PIP and the *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. RMHP R1 resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2023–2024 PIP Overall Confidence Levels for RMHP R1

PIP Title	Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
FUH 7-Day and 30-Day in RAE BH Members	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
	Resubmission	*Not Applicable*			*Not Assessed*		
Improving the Rate of SDOH Screening for RAE Members in Region 1	Initial Submission	67%	50%	*Low Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

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

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

The *FUH 7-Day and 30-Day in RAE BH Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP 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.

The *Improving the Rate of SDOH Screening for RAE Members in Region 1* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP R1 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

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 D: 1,283	39.52%					

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 D: 1,283	61.50%					

N–Numerator D–Denominator

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 39.52 percent, and the percentage of discharges who had a follow-up visit within 30 days was 61.50 percent.

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 D: 54,361	5.06%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP R1 reported that 5.06 percent of eligible RAE members who had at least one billed encounter were screened for SDOH during the measurement year.

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 the health plan 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
• Lack of access to timely BH visits • Lack of care coordination activities	Behavioral Health Provider Incentive Program

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

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

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

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 baseline performance indicator results for both PIPs, and both PIPs were validated through Step 8 (Design and Implementation). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages.

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. RMHP R1 will progress to reporting Remeasurement 1 indicator results for both PIPs, and both PIPs will progress to being evaluated for achieving significant improvement for next year's validation.

Recommendations

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

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The 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 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

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

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

Performance Improvement Projects

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 90th HEDIS national benchmark available (MY2021) was 60.58%. The FUH-AD 30-day rate was 61.50% using administrative claims data. The most recent 90th HEDIS national benchmark available (MY2021) was 72.01%. RMHP has consistently performed at the 25th 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 2023-24 PIP Submission Form**
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

Performance Improvement Projects

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 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

Performance Improvement Projects

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

The population definition must:

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

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.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
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.

- 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.

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

***Appendix A*: State of Colorado 2023-24 PIP Submission Form**
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

Performance Improvement Projects

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

The population definition must:

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

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
- 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

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
for Rocky Mountain Health Plan (RAE 1)

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 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

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

Indicator 1	**Follow-up after hospitalization for mental illness – 7-day (CMS Core Measure FUH-AD)**
	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.
Numerator Description:	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.
Denominator Description:	RAE beneficiaries aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.
Baseline Measurement Period	07/1/2022 to 06/30/2023 using 2023 CMS Core Measure Technical Specifications
Remeasurement 1 Period	07/1/2023 to 06/30/2024 using 2024 CMS Core Measure Technical Specifications
Remeasurement 2 Period	07/1/2024 to 06/30/2025 using 2025 CMS Core Measure Technical Specifications

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Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow--Up)
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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."

Mandated Goal/Target, if applicable	N/A
Indicator 2	**Follow-up after hospitalization for mental illness – 30-day (CMS Core Measure FUH-AD, NQF #0576)**
	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.
Numerator Description:	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.
Denominator Description:	RAE beneficiaries aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.
Baseline Measurement Period	07/1/2022 to 06/30/2023 using 2023 CMS Core Measure Technical Specifications

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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."

Remeasurement 1 Period	07/1/2023 to 06/30/2024 using 2024 CMS Core Measure Technical Specifications
Remeasurement 2 Period	07/1/2024 to 06/30/2025 using 2025 CMS Core Measure Technical Specifications
Mandated Goal/Target, if applicable	N/A
Use this area to provide additional information.	

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

The data collection methodology must include the following:

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

Data Sources (Select all that apply)

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

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	Estimated percentage of reported administrative data completeness at the time the data are generated: 99.52% complete. Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: a. Identify the claims (both paid and IBNR) by Date of Service (DOS) and Input Date (date entered into the claims payment system) b. Pivot data into a table by DOS and Input Date and calculate the percentage of claims input within 60 days and 90 days from the DOS as compared to the total number of claims to date by DOS month (claims input within 60 or 90 days divided by total claims to date) c. Calculate the average completeness across months by 60 and 90 days (% complete for month averaged across all months) d. Calculate the Fiscal Year Completeness with 60 days runout (sum of all fiscal year claims through 2 months after the end of the fiscal year divided by the sum of all claims collected for the fiscal year). This rate will change as we receive additional claims, but by no more than an estimated 7-8% (determined by the average lag by month). Note this is	

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- 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.

	not the impact on the measures, only on data completeness of administrative data. e. Impact on Rates calculated by taking the HEDIS rate calculation for the month following the end of the fiscal year (July 2023) compared to the most recent run of HEDIS rates (October 2023).	

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 *p* 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					
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 *p* Value
01/01/2022-12/31/2022	Baseline	789	1283	61.50%	N/A for baseline	N/A for baseline
01/01/2023-12/31/2023	Remeasurement 1					
01/01/2024-12/31/2024	Remeasurement 2					

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

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

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

Baseline Narrative:

The baseline findings for 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:

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.).

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

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

Intervention Title	Barrier(s) Addressed
Behavioral Health Provider Incentive Program	- Access to timely behavioral health visits - Conducting care coordination activities

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

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

Demographic Information	
MCO Name: Rocky Mountain Health Plans	
Project Leader Name: Kimberly Herek	Title: Director of Quality Improvement
Telephone Number: _____	Email Address: Kimberly.Herek@uhc.com
PIP Title: **Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1**	
Submission Date: 10/31/2023	
Resubmission Date (if applicable): 02/02/2024	

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Performance Improvement Projects

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 are reported below in section 7. **Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:** Growing evidence shows that addressing unmet SDoH needs like homelessness, hunger, and exposure to violence, can mitigate the harm of situational factors to a person's overall health. As with clinical assessment tools, providers can use the results from SDoH screening tools to inform patients' treatment plans and make referrals to community services.

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Performance Improvement Projects

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

The statement(s) should:

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

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

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply. **The population definition must:** ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. ◆ Include the age range and the anchor dates used to identify age criteria, if applicable. ◆ Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3. ◆ Capture all members to whom the statement(s) applies. ◆ Include how race and ethnicity will be identified, if applicable. ◆ If members with special healthcare needs were excluded, provide the rationale for the exclusion.
Population definition: All unique Members enrolled in CHP+ 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 SFY22- 23. **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

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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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Performance Improvement Projects

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

The description of the Indicator(s) must:

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

Indicator 1	**SDoH Screening Rate for Unique Members in Clinical Settings**
	The improvement of SDoH screening rates is a mandated PIP topic for SFY24. RMHP is defining the performance indicator as screening rates for *unique* members, which will produce more precise results (versus reporting an overall count of SDoH screeners); this will allow for an analysis of screening patterns to inform future interventions to improve screening rates. This indicator (and overall PIP strategy) is specific to SDoH screeners completed in the clinical setting at in-network provider facilities and is separate from/does not include RMHP's Care Management strategy to improve SDoH screening rates.
Numerator Description:	Number of unique members with a completed SDoH screener in the measurement year
Denominator Description:	Number of enrollees in the ACC during the measurement year who had at least one billed encounter in the measurement year
Baseline Measurement Period	07/1/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025

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Performance Improvement Projects

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- 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."

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

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

The data collection methodology must include the following:

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

Data Sources (Select all that apply)

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

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	Estimated percentage of reported administrative data completeness at the time the data are generated: _100_ % complete. **Description of the process used to calculate the reported administrative data completeness percentage**. The data collected to report the numerator of the performance indicator was derived from AHCM screener data from QHN and state enrollment files. The AHCM data was transferred to the RMHP SQL Server in a daily feed. The numerator reported in the baseline data was gathered in September 2023 for the measurement period ending on June 30th, 2023; since RMHP received AHCM 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 an AHCM screener with the member, the AHCM 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 data (resulting in 100% completeness rate for screener-to-member match for this component of the data set).	

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	Include a narrative of how claims lag may have impacted the data reported: 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.	

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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 baseline measurement period, AHCM screens and RMHP member enrollment data were the two elements collected.

Data Collection Process:

- The RMHP Data Analytics team extracted AHCM screening data for screeners that occurred within the 12-month reporting period (July 1, 2022 – June 30, 2023) 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 AHCM screening data. A scrub was completed comparing the Medicaid ID and member identification factors (DOB, first/last name, address) to validate that the AHCM member demographic information 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 AHCM screening totals
- The numerator data (count of AHCM screeners) was deduplicated by unique member in the final baseline 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

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1
for Rocky Mountain Health Plan (RAE 1)

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

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

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

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022-06/30/2023	Baseline	2749	54,361	5.06%	N/A for baseline	N/A for baseline
07/01/2023-06/30/2024	Remeasurement 1					
07/01/2024-06/30/2025	Remeasurement 2					

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1
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Performance Improvement Projects

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:

Baseline to Remeasurement 2 Narrative:

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

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

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

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	• Less engagement from providers when work is not reimbursed • No code specifically set to reimburse screening for SDOH
Provider Coaching	• High rates of staff turnover require periodic re-training • SDOH screening and intervening appropriately can lead to cumbersome workflows

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

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

	• 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 B. Final PIP Validation Tools

The following contains the final PIP Validation Tools for RMHP R1.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
FUH 7-Day and 30-Day Follow-Up
for Rocky Mountain Health Plan (RAE 1)

Demographic Information			
MCO Name:	Rocky Mountain Health Plan (RAE 1)		
Project Leader Name:	Kim Herek	**Title:**	Quality Improvement Director
Telephone Number:	402-917-1833	**Email Address:**	Kimberly.herek@uhc.com
PIP Title:	*Follow-Up After Hospitalization for Mental Illness (FUH) in RAE BH Members (7-Day and 30-Day Follow-Up)*		
Submission Date:	October 31, 2023		
Resubmission Date:	Not Applicable		

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for Rocky Mountain Health Plan (RAE 1)

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

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

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

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

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for Rocky Mountain Health Plan (RAE 1)

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

Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [NA]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	5	2	*NA*

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

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

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	0	*NA*

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

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

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	1	*NA*

* "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 2023-24 PIP Validation Tool
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Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	7	3	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
FUH 7-Day and 30-Day Follow-Up
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	**Validation Feedback:** In the intervention worksheet, the health plan documented intervention effectiveness measure evaluation period dates that aligned with the annual measurement periods for the overall performance indicator. HSAG recommends that shorter intervention evaluation periods, such as monthly or quarterly, be used to determine intervention effectiveness and allow for mid-year intervention refinements. The health plan should document intervention evaluation periods that occur more frequently than annually and provide evaluation results of those more frequent evaluation periods in next year's annual submission.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
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for Rocky Mountain Health Plan (RAE 1)

Results for Step 7 - 8			
Total Evaluation Elements	**8**	**4**	**Critical Elements**
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
FUH 7-Day and 30-Day Follow-Up
for Rocky Mountain Health Plan (RAE 1)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. 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. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
FUH 7-Day and 30-Day Follow-Up
for Rocky Mountain Health Plan (RAE 1)

Table B—1 2023-24 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	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	2	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				1	*Not Assessed*			
Totals for All Steps	**26**	**12**	**0**	**0**	**7**	**13**	**8**	**0**	**0**	**3**

Table B—2 2023-24 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* *	***100%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***High Confidence***

Table B—3 2023-24 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* *	***Not Assessed***
Percentage Score of Critical Elements *Met* **	***Not Assessed***
Confidence Level***	***Not Assessed***

* 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 Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** 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 2023-24 PIP Validation Tool
FUH 7-Day and 30-Day Follow-Up
for Rocky Mountain Health Plan (RAE 1)

Performance Improvement Projects

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***Not Assessed***

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving the Rate of SDOH Screening for RAE Members in Region 1
for Rocky Mountain Health Plan (RAE 1)

Demographic Information			
MCO Name:	Rocky Mountain Health Plan (RAE 1)		
Project Leader Name:	Kimberly Herek	**Title:**	Director of Quality Improvement
Telephone Number:	Not Applicable	**Email Address:**	Kimberly.Herek@uhc.com
PIP Title:	*Improving the Rate of Social Determinants of Health (SDOH) Screening for RAE Members in Region 1*		
Submission Date:	October 31, 2023		
Resubmission Date:	February 2, 2024		

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

* "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 2023-24 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
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *NA* is not applicable to this element for scoring	C*	*Met*	The health plan should clarify the language "leveraging various SDOH screening tools" in the Aim statement. This language suggests that the health plan will be using various unspecified SDOH screening tools to screen members; however, the performance indicator documented in Step 5, the data collection process documented in Step 6, and the attached screening tool suggest that a single SDOH screening tool, the CMS Accountable Health Communities Health-Related Social Needs (AHC HRSN) screener, would be used to identify members for the numerator. HSAG recommends that the health plan revise the Aim statement to align with the screening tool documented throughout the PIP submission. **Resubmission February 2024:** The health plan revised the Aim statement to align with the revised performance indicator and data collection process, as discussed in the January 2024 technical assistance call with HSAG and the Department. The validation score for this evaluation element has been changed to *Met*.

Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *NA* is not applicable to this element for scoring.	C*	*Met*	The health plan specified members enrolled in state fist year (SFY) 2022-23 for the PIP population. The population definition in Step 3 should apply for all measurement periods; therefore, the health plan should remove references to a specific year from the population documentation in Step 3. **Resubmission February 2024:** The health plan revised the Step 3 documentation to apply to all measurement periods. The initial feedback was addressed and the validation score for this evaluation element has been changed to *Met*.
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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

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

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

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	The health plan should revise the numerator description to clarify if, "SDOH screeners" is referring to the AHC HRSN screening tool or multiple types of screening tools. In addition, the health plan should specify how a "completed" screening is defined. If multiple screening tools are being used, the health plan should submit each tool as an attachment with the PIP resubmission. Each screening tool must, at a minimum, address the four social determinants identified by the Department in February 2023: housing instability, food insecurity, transportation problems, and utility needs. HSAG recommends a technical assistance call to discuss the performance indicator definition and the relationship between the numerator and denominator descriptions to ensure a methodologically sound performance indicator is defined for the PIP. **Resubmission February 2024:** Following the January 2024 technical assistance session, the health plan revised the numerator and denominator descriptions in alignment with the documentation revisions for Steps 2 and 6. The validation score for this evaluation element has been changed to *Met*.
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5

Total Evaluation Elements**	2	1	Critical Elements**
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *NA* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *NA* is not applicable to this element for scoring.	C*	*Met*	In the Step 7 Baseline Narrative, the health plan reported that the type of SDOH screening tool and data collection sources will change for the remeasurement period and that future remeasurements would include different tools. The data collection process for producing indicator results should be comparable for each measurement period. HSAG recommends a technical assistance call to better understand the health plan's data collection plan and to discuss the best approach for producing comparable indicator results for each measurement period. **Resubmission February 2024:** The health plan revised the Step 6 data collection process description to address the feedback provided in the January 2024 PIP technical assistance call. The validation score for this evaluation element has been changed to *Met*.
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*NA*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	1	*NA*

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

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Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	8	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	6	3	*NA*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool
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Results for Step 7 - 8			
Total Evaluation Elements	**8**	**4**	**Critical Elements**
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. 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. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 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 2023-24 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	2	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				1	*Not Assessed*			
Totals for All Steps	**26**	**13**	**0**	**0**	**6**	**13**	**8**	**0**	**0**	**3**

Table B—2 2023-24 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 2023-24 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**	***Not Assessed***
Percentage Score of Critical Elements *Met* **	***Not Assessed***
Confidence Level***	***Not Assessed***

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

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EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
IISAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***Not Assessed***