COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2022–2023 Accountable Care Collaborative Regional Accountable Entity Compliance Review Aggregate Report

June 2023

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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1. Overview

Executive Summary

The purpose of this report is to summarize the compliance scores, strengths, and recommendations for the Regional Accountable Entities (RAEs). Four standards were reviewed in fiscal year (FY) 2022–2023: Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Standard XII—Enrollment and Disenrollment was the highest scoring standard during this review cycle, showing the RAEs had a strong understanding of enrollment data procedures and quality assurance measures to ensure data were accurately accepted into the system in the order in which members were enrolled. While the RAEs still struggled the most with the two standards with record reviews (Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems), scores showed improvements from the previous review cycle.

Background

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

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

The RAEs included in this report are:

Medicaid RAE Name	RAE Region
Rocky Mountain Health Plans (RMHP)	RAE 1
Northeast Health Partners (NHP)	RAE 2
Colorado Access (COA)	RAE 3
Health Colorado, Inc. (HCI)	RAE 4
COA	RAE 5
Colorado Community Health Alliance (CCHA)	RAE 6
CCHA	RAE 7

Methodology

Between January 2023 and April 2023, HSAG performed a virtual review of each RAE to assess compliance with Medicaid managed care regulations and with State contract requirements. The Department requested a review of four managed care standards to evaluate compliance with managed care regulations. The standards chosen were:

Standard	Title
Standard I	Coverage and Authorization of Services
Standard II	Adequate Capacity and Availability of Services
Standard VI	Grievance and Appeal Systems
Standard XII	Enrollment and Disenrollment

HSAG developed a review strategy and compliance monitoring tools based on these four standards to review the performance areas chosen. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*.

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

Summary of Compliance With Managed Care Regulations

For the FY 2022–2023 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements: Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance review scores for individual standards are included in each region's RAE compliance review report along with details regarding strengths, opportunities for improvement, and required actions based on noncompliance with regulations.

Summary of Compliance Scores for Fiscal Year 2022–2023

Table 2-1 presents comparative RAE scores aggregated for all standards reviewed in FY 2022–2023.

Table 2-1—Summary of FY 2022–2023 Total Scores

RAE	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
RAE 1	86	86	81	5	0	0	94%
RAE 2	86	86	79	7	0	0	92%
RAE 3	86	86	81	5	0	0	94%
RAE 4	86	86	79	7	0	0	92%
RAE 5	86	86	81	5	0	0	94%
RAE 6	86	86	75	11	0	0	87%
RAE 7	86	86	75	11	0	0	87%
Total	**602**	**602**	**551**	**51**	**0**	**0**	**92%**

* Green shading indicates above 90% compliance.

Overall, scores across the four standards reviewed in FY 2022–2023 were moderately high, ranging from 87 to 94 percent compliance, demonstrating a broad understanding of the regulations. For the seven RAEs, each review contained 86 elements across the four standards.

Statewide Summary of RAE Compliance Scores by Standard Over Three Years

Table 2-2 presents comparative RAE scores for all standards reviewed from FY 2020–2021 through FY 2022–2023.

Table 2-2—Summary of Statewide Standards From FY 2020–2021 to FY 2022–2023

Standard and Applicable Review Years	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Statewide Average
Standard I—Coverage and Authorization of Services (2022–2023)	**94%^**	**91%v**	**91%^**	**94%v**	**88%^**	**94%^**	**94%^**	**92%^**
Standard II—Adequate Capacity and Availability of Services (2022–2023)	**92%v**	**93%v**	**100%~**	**86%v**	**100%~**	**100%^**	**100%^**	**96%v**
Standard III—Coordination and Continuity of Care (2021–2022)	100%~	100%^	100%~	100%^	100%^	90%v	90%v	97%^
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	100%^	100%~	100%~	100%~	100%~	100%~	100%~	100%^
Standard V—Member Information Requirements (2021–2022)	89%^	86%v	94%~	86%v	94%~	87%^	87%^	89%v
Standard VI—Grievance and Appeal Systems (2022–2023)	**94%^**	**91%^**	**94%^**	**91%^**	**97%^**	**74%^**	**74%~**	**88%^**
Standard VII—Provider Participation and Program Integrity (2020–2021)	94%	94%	100%	94%	100%	100%	100%	97%
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	94%	100%	94%	100%	100%	100%	98%

Standard and Applicable Review Years	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Statewide Average
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	75%	75%	100%	75%	100%	100%	100%	89%
Standard X—Quality Assessment and Performance Improvement (2020–2021)	100%	100%	100%	100%	100%	100%	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2021–2022)	100%~	86%v	100%^	86%v	100%^	86%^	86%^	92%^
Standard XII—Enrollment and Disenrollment (2022–2023)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*Bold text indicates standards that HSAG reviewed during FY 2022–2023. Scores are compared across three years.

Green carrot indicates an increase from review three years prior. Red carrot indicates a decrease from review three years prior.

~ Indicates no change from prior year.

Beginning July 1, 2018, the RAEs began operations. Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement were reviewed for the first time in FY 2020–2021 and no comparison is available. Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023; therefore, no comparison is available.

Of the four standards reviewed in FY 2022–2023, Standard XII—Enrollment and Disenrollment had the highest compliance score, achieving 100 percent compliance. Standard VI—Grievance and Appeal Systems, the lowest scoring standard in FY 2022–2023, received a score of 88 percent compliance; however, the standard improved from the previous review. Notably, both standards with record reviews (Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems) improved from the prior review. An overview of compliance scores from previous years can be found in the *FY 2021–2022 External Quality Review Technical Report for Health First Colorado*, and further analysis across standards will be presented in the *FY 2022–2023 External Quality Review Technical Report for Health First Colorado* in January 2024.

3. Summary of Strengths and Recommendations

HSAG noted the following observations and recommendations related to the four standards reviewed in FY 2022–2023.

Summary of Strengths

Standard I—Coverage and Authorization of Services

- Each RAE submitted policies and procedures that outlined its comprehensive approach to review and authorize covered services using the Department's definition of "medical necessity" and other nationally recognized review criteria.
- All RAEs met the requirement to conduct interrater reliability (IRR) testing to ensure consistent application of review criteria. Five out of seven RAEs set and met IRR testing goals above 90 percent.
- All RAEs employed the necessary clinical staff members to process service authorization requests. Denial records reviewed demonstrated that staff members with the appropriate level of clinical expertise reviewed requests from providers and made denial decisions. Additionally, the RAEs had either internal or contracted specialty clinical expertise available to review specialty cases.
- Some (three or less) RAEs clearly documented outreach to the provider when additional information or clarification was needed to make a final determination regarding a service request.
- Six out of seven RAEs demonstrated 90 percent compliance or higher for denial records reviewed.
- Most (four or more) RAEs demonstrated member-friendly language, at or around the sixth grade reading level, within the notice of adverse benefit determination (NABD) samples reviewed.
- All RAEs had policies regarding emergency services and poststabilization procedures, and the definitions were consistent across provider- and member-facing information. Staff members from each RAE were able to clearly describe how claims processing systems were monitored to ensure claims passed through appropriately for emergency services. Staff members from each RAE were able to clearly describe how the claims and utilization management departments worked together to ensure poststabilization services were properly addressed.

Standard II—Adequate Capacity and Availability of Services

- Each RAE submitted policies, procedures, quarterly and annual reporting, as well as provider-facing information to demonstrate oversight of the provider network and range of covered services offered to members. Most included accurate information regarding time and distance standards and timely appointment standards.
- While all RAEs participated in network adequacy activities quarterly, best practices were identified for RAEs that held routine committee discussions regarding member utilization trends, discussed

access to care complaints, explored membership demographics, and implemented barrier reduction strategies.

- All RAEs informed their provider networks about timely appointment expectations and monitored providers to some extent, including procedures to enlist corrective action plans (CAPs) as necessary. Best practices for monitoring the provider network's adherence to timely appointment standards included secret shopper surveys and direct audits of the provider's scheduling system. Best practices for follow-up on CAPs were observed in the RAEs who scheduled follow-ups within 90 days to ensure resolutions.

Standard VI—Grievance and Appeal Systems

- All RAEs demonstrated adequate systems to document grievances and appeals, including robust processes to ensure appeals and grievances were accepted orally or in writing. All RAEs conducted staff trainings at the time of onboarding; most held refresher trainings annually, and some described monthly and ad hoc trainings.
- Most RAEs resolved grievances within the 15 working day time frame and appeals within the 10 working day time frame. Notably, one RAE demonstrated full compliance, receiving 100 percent for both the grievance and appeal record reviews.
- All RAEs forwarded member appeal requests that required clinical expertise to a clinical expert who was not involved in the original denial decision. If the original denial decision was upheld, most RAEs included accurate information in regard to how to request a State fair hearing and the time frame.
- Staff members discussed monitoring grievance and appeal systems and procedures through methods such as monthly audits and documentation reviews. If a staff member missed a time frame or did not include all required content, supervisors would typically engage in a one-on-one training.
- Best practices for the RAEs included tracking and trending grievances and appeals for opportunities for improvement through committee discussions. Other best practices included utilizing extensions to allow additional time if the member requested additional time or the RAE felt it was in the best interest of the member.

Standard XII—Enrollment and Disenrollment

- All RAEs submitted procedures regarding receiving the Electronic Data Interchange 834 files from the Department, and the RAEs typically downloaded the files five days a week.
- Staff members from each RAE were able to speak to procedures for identifying necessary edits, updates, and other reconciliation issues.
- While none of the RAEs reported any issues that escalated to the extent that disenrollment of a member was requested, many RAEs described steps to engage a member with extremely disruptive behavior with care coordination or, in some cases, a communication plan. During this process, RAE staff members described ongoing communication with the Department.

Opportunities for Improvement and Recommendations

Standard I—Coverage and Authorization of Services

- Two RAEs produced NABDs which included acronyms or clinical terminology that could be explained in a more member-friendly manner. HSAG recommends additional internal review and plain language explanations to accompany clinical information, whenever possible.
- For two RAEs, HSAG recommends including specific references to clinical criteria (i.e., InterQual) reviewed within the NABD letter. Although not a federal requirement, the State RAE NABD template encourages the RAE to include a reference to the RAE or their criteria.
- HSAG noted an opportunity for two RAEs to document the nuances of the claims system and instances where emergency services claims are allowed to pass through. The documentation could then serve as a basis for annual review to ensure coding and claims adjudication procedures are current.
- Most RAEs had the opportunity to use extensions for denial decisions, when in the best interest of the member. Some RAEs used shortened time frames in which providers were allowed to submit additional documentation or have a peer to peer, in some cases as short as an hour (for expedited requests) and in other cases 24 hours (in standard requests). HSAG encourages the RAEs to consider using the full review time frame whenever needed and extensions, when appropriate.

Standard II—Adequate Capacity and Availability of Services

- All RAEs reported gaps in substance use disorder (SUD) access to care, particularly notable gaps in 3.3 and 3.7 WM. In addition, many RAEs reported gaps related to accessing psychiatric hospitals and psychiatric units in acute care hospitals in rural and frontier counties. Therefore, all RAEs have an opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., American Society of Addiction Medicine levels 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM) and access to psychiatric hospitals and psychiatric units in acute care hospitals.
- Staff members from each RAE could describe how single case agreements were completed as expeditiously as possible, but most RAEs could benefit from a more formalized tracking mechanism to ensure that services that are not available within the provider network are provided in a timely manner out of network.
- Two RAEs did not provide the minimum hours of 8:00 a.m. to 5:00 p.m. for behavioral health providers in documentation. HSAG recommends adding this information to a provider agreement, provider manual, or other similar documentation to clearly communicate the expectation with providers.
- HSAG recommends for all RAEs to increase efforts to monitor the behavioral health provider network's adherence to timely appointment standards.

Standard VI—Grievance and Appeal Systems

- Most RAEs have the opportunity to use extensions, when in the best interest of the member. Some RAEs used shortened time frames in which members or providers were allowed to submit additional documentation. HSAG encourages the RAEs to consider using the full review time frame whenever needed and considering extensions, when appropriate.
- Two RAEs had an opportunity to include more detailed documentation in system notes and communications between the RAE and members/member representatives for further context of the case and to capture all efforts regarding investigations and information gathering activities.
- Two RAEs required the member to sign a release of information for the RAE to investigate grievances. HSAG recommends the RAE clarify with the Department the Health Insurance Portability and Accountability Act laws that may or may not apply regarding when information can be shared for treatment purposes.

Standard XII—Enrollment and Disenrollment

- Three RAEs had the opportunity to develop a mechanism to compare disenrollment files to member-reported quality-of-care concerns for tracking and trending purposes.

Required Action Trends

Standard I—Coverage and Authorization of Services

- Most RAEs were required to enhance procedures and monitoring efforts to ensure that denial notices were sent to the member timely. Common findings in the record reviews consisted of timeliness issues regarding the denial decision and/or notification time frame and inaccurate or missing content within the NABD.
- Two RAEs were required to update procedures to further delineate provider claims issues as separate from member-related issues in which a service is denied or partially denied. In addition, both RAEs must ensure that the member is notified in writing of the denial or partial denial of a service in a timely manner.
- Two out of seven RAEs were required to update policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD.

Standard II—Adequate Capacity and Availability of Services

- Three out of the seven RAEs were required to make minor updates to policies, procedures, and other supporting documentation to state the current time and distance standards related to urgent services and nonurgent care visits and should include the exceptions related to when well-care visits should be scheduled prior to one month.
- One RAE was required to engage in additional efforts to identify any cultural barriers to accessing healthcare services and to gain an understanding of the membership's cultural norms and practices

regarding access to healthcare. Furthermore, HSAG suggests the RAE review current data, trends, cultural sub-groups, and community partners as sources of information to explore.

Standard VI—Grievance and Appeal Systems

- All RAEs had findings regarding language in either member letters, policies, procedures, websites, or other supporting documentation that incorrectly stated the member needed to follow up an oral appeal request in writing. The RAEs were required to update supporting documentation that required the member to follow up an oral request in writing, as this is no longer required in federal regulations.
- Two out of seven RAEs did not demonstrate full compliance for grievance record reviews, and four out of seven RAEs did not demonstrate full compliance for appeal record reviews. Two notable trends for findings were untimely member letters and letters that lacked the required content. The RAEs with partially met scores were required to enhance procedural and staff member monitoring and update template letters.

Standard XII—Enrollment and Disenrollment

- HSAG identified no required actions for this standard for all RAEs.