COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2023–2024 Accountable Care Collaborative Regional Accountable Entity Compliance Review Aggregate Report

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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) 2023–2024:

- Standard V—Member Information Requirements
- Standard VII—Provider Selection and Program Integrity
- Standard IX—Subcontractual Relationships and Delegation
- Standard X—Quality Assessment and Performance (QAPI), Clinical Practice Guidelines, and Health Information Systems

Consistent with the prior review of this standard, RAEs maintained 100 percent scores for Standard X—QAPI, indicating that the RAEs had a strong understanding how to maintain an active quality program that prioritizes the ongoing monitoring of activities and addresses key indicators. Additionally, the RAEs showed a strong understanding of clinical practice guidelines procedures and processes, and had robust health information systems. Further, HSAG found that each of the health plans either improved or maintained its scoring from the prior reviews for Standard V—Member Information, resulting in an improved aggregate score. The RAEs struggled the most with Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation, as a decline in scores was observed following the previous review cycle.

2. Overview

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 their 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 2024 and April 2024, HSAG performed a review of each RAE to assess its 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 V—Member Information Requirements
- Standard VII—Provider Selection and Program Integrity
- Standard IX—Subcontractual Relationships and Delegation
- Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems

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.

3. Statewide Summary of Results

Summary of Compliance With Managed Care Regulations

For the FY 2023–2024 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements: Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance (QAPI), Clinical Practice Guidelines, and Health Information Systems. 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 2023–2024

Table 3-1 presents comparative RAE scores aggregated for all standards reviewed in FY 2023–2024.

Table 3-1—Summary of FY 2023–2024 Total Scores

RAE	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
RAE 1	54	54	53	1	0	0	98%
RAE 2	54	54	48	5	1	0	89%
RAE 3	54	54	49	5	0	0	91%
RAE 4	54	54	48	5	1	0	89%
RAE 5	54	54	49	5	0	0	91%
RAE 6	54	54	53	1	0	0	98%
RAE 7	54	54	53	1	0	0	98%
Total	**378**	**378**	**353**	**23**	**2**	**0**	**93%**

Note: Green shading indicates above 90 percent compliance.

For the seven RAEs, each review contained 54 elements across the four standards. Overall in FY 2023–2024, total scores for the RAEs varied from moderate (80 percent to 89 percent) to high (90 percent to 100 percent), ranging from 87 percent to 98 percent compliance, thus demonstrating a broad understanding of the regulations. In Table 3-1, high total scores are shaded green and moderate scores are not shaded.

Statewide Summary of RAE Compliance Scores by Standard Over Three Years

Table 3-2 presents comparative RAE scores for all standards reviewed from FY 2021–2022 through FY 2023–2024.

Table 3-2—Summary of Statewide Standards From FY 2021–2022 to FY 2023–2024

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 (2023–2024)	**100%^**	**100%^**	**94%~**	**100%^**	**94%~**	**100%^**	**100%^**	**98%^**
Standard VI—Grievance and Appeal Systems (2022–2023)	94%^	91%^	94%^	91%^	97%^	74%^	74%~	88%^
Standard VII—Provider Selection and Program Integrity (2023–2024)	**100%^**	**75%v**	**94%v**	**75%v**	**94%v**	**100%~**	**100%~**	**91%v**
Standard VIII—Credentialing and Recredentialing (2020–2021)	100%	94%	100%	94%	100%	100%	100%	98%
Standard IX—Subcontractual Relationships and Delegation (2023–2024)	**75%~**	**50%v**	**25%v**	**50%v**	**25%v**	**75%v**	**75%v**	**54%v**

Standard and Applicable Review Years	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Statewide Average
Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems (2023–2024)	**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 2023–2024. Scores are compared across three years.

^ indicates an increase from review three years prior.

v indicates a decrease from review three years prior.

~ Indicates no change from prior year.

Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023; therefore, no comparison is available.

Of the four standards reviewed in FY 2023–2024, the RAEs demonstrated their greatest strength with Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, as all RAEs achieved 100 percent for this standard. For Standard V—Member Information Requirements, all of the RAEs either improved compared to the prior review or maintained their scores. All plans demonstrated strength in this standard, as individual RAEs scored 94 percent or above, and the cumulative score for all RAEs was 98 percent. Although the RAEs scored lower than the previous review year for Standard VII—Provider Selection and Program Integrity, three of the RAEs scored 100 percent and the aggregate score was 91 percent. For Standard IX—Subcontractual Relationships and Delegation, the lowest scoring standard in FY 2023–2024, RAEs received an aggregate score of 54 percent, which was a decline from the prior review of this standard. An overview of compliance scores from previous years can be found in the *FY 2022–2023 External Quality Review Technical Report for Health First Colorado*, and further analysis across standards will be presented in the *FY 2023–2024 External Quality Review Technical Report for Health First Colorado*, scheduled to be released in January 2025.

4. Summary of Strengths and Recommendations

HSAG noted the following observations and recommendations related to the four standards reviewed in FY 2023–2024.

Summary of Strengths

Standard V—Member Information Requirements

- The RAEs provided information to members during initial enrollment as well as upon request, at no cost, in English and the prevalent non-English language (Spanish) as well as in alternate formats. In addition, the RAEs developed member materials using easily understood language at or around a sixth-grade reading level. Information made available electronically was found to be compliant with guidelines for Section 508 of the Rehabilitation Act.
- The RAEs had processes in place to ensure the accuracy of the provider directory. The RAEs made provider directories available to members electronically and, upon request, in paper form. Provider directories could be downloaded or printed from each RAE website and were machine-readable.
- The RAEs participated in member advisory committees to gather feedback to determine whether members had a good understanding of the member material. Some RAEs facilitated additional member workgroups where members tested materials and content for readability purposes.
- The RAEs trained their customer service teams on member benefits using routine training, periodic training, and one-on-one communication to ensure that team members were knowledgeable and able to provide members with assistance when needed.

Standard VII—Provider Selection and Program Integrity

- Generally, the RAEs were able to provide an adequate overview of their credentialing program, including how they address recruitment and retention, how they review provider applications, and how the credentialing process captures the required information for vetting. In addition, some RAEs included policies and procedures that pertained to the selection and retention of providers and how the RAE targets outreach with a focus on specialty providers.
- The RAEs communicated methods for reporting fraud, waste, or abuse (FWA) to providers through the provider agreements and provider manuals, and to staff members through onboarding and annual trainings.
- The RAEs described a comprehensive compliance program with detailed oversight, monitoring, and reporting processes.

Standard IX—Subcontractual Relationships and Delegation

- The RAEs provided written delegation agreements that included some or most of the required language obligating the subcontractor to comply with all applicable laws, regulations, subregulatory

guidance, and contract provisions, and to monitor and provide oversight of subcontractors and delegates through audits and internal discussions.

Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems

- All RAEs provided evidence of QAPI programs that detailed leadership structures, goals and objectives, and program components that encompassed both physical and behavioral health.
- Two RAEs described how quality and appropriateness of care for members with special healthcare needs was addressed through various care management initiatives, and they included the identification of treatment barriers and the supports needed to improve member health outcomes.
- The RAEs demonstrated strategies for ongoing review of utilization criteria, identifying inpatient utilization trends, and assuring timely utilization management (UM) decisions, as well as a process that assessed the interrater reliability of decision makers.
- Clinical practice guidelines were adopted, disseminated, and reviewed at least biennially, and included a process for soliciting feedback from contracted providers. Clinical practice guidelines were accessible to providers and members via the RAE websites.
- The health information systems for the RAEs were robust and included methods to collect, process, and report data to and from the State.

Recommendations and Opportunities for Improvement

Standard V—Member Information Requirements

- For some of the RAEs, HSAG found that taglines in member letters and member notices did not include the same components in both English and Spanish. HSAG recommended that the RAEs conduct a review of their written member materials to ensure that all taglines are consistent in both English and Spanish.
- HSAG recommended that one RAE update a statement on its website, and in any other member materials where applicable, to indicate what kinds of media were available to the member.
- Provider directories did not include information about the availability of accessible medical equipment and exam rooms as part of the provider directory information. HSAG recommended incorporating available accommodations into the provider directory filters.

Standard VII—Provider Selection and Program Integrity

- HSAG recommended that two RAEs expand their selection and retention of providers policies to include the details regarding provider retention monitoring efforts that were described during the interview, as well as any provider training and professional networking opportunities.
- HSAG encouraged two RAEs to further detail their expectations regarding prompt reporting timelines in their employee training and related policies. Additionally, HSAG recommended that the RAEs document compliance training expectations for its compliance officer and management-level staff members.

- While two RAE provider agreements clearly stated that members were not held liable for the provider's debts, services, or payments, as outlined in 42 CFR § 438.106, the RAEs had an opportunity to further clarify in the compliance operations manual that the members are not held liable for:
  - Debts in the event of the contractor's insolvency.
  - Covered services provided to the member for which the State does not pay the RAE.
  - Covered services provided to the member for which the State or the RAE does not pay the healthcare provider that furnishes the services under a contract, referral, or other arrangement.
  - Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the RAE provided the services directly.
- For two of the RAEs, HSAG recommended revisions to credentialing policies to include language stating that the RAE complies with the National Committee for Quality Assurance (NCQA) guidelines for credentialing and recredentialing providers.
- HSAG recommended that two of the RAEs revise their policies to include the terms "excluded, suspended, and debarred" throughout the document to maintain consistency with the policy statement.

Standard IX—Subcontractual Relationships and Delegation

- HSAG did not identify any opportunities for improvements or recommendations related to Subcontractual Relationships and Delegation.

Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems

- HSAG did not identify any opportunities for improvements or recommendations related to QAPI, Clinical Practice Guidelines, and Health Information Systems.

Required Action Trends

Standard V—Member Information Requirements

- For two of the RAEs, the provider directories did not include the provider website uniform resource locators (URLs), as required.

Standard VII—Provider Selection and Program Integrity

- Two of the RAEs must revise their policies to include language stating the RAE does not "discriminate against providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Four out of the seven RAEs must revise their policies to include the terms "excluded, suspended, and debarred" to ensure that each does not knowingly have a director, officer, partner, employee,

consultant, subcontractor, or owner (i.e., owning 5 percent or more of the contractor's equity) who is excluded, suspended, or otherwise debarred from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.

- Two of the RAEs delegated management of their compliance programs operationally and functionally. While the delegate was able to describe features of the compliance program, including an active compliance committee, the RAEs did not have a role in leading the compliance program nor any oversight and monitoring to ensure that the activities were fully compliant with State and federal requirements. While the delegate described quarterly compliance meetings between the delegate and the RAEs, the RAEs provided no evidence that they or their compliance officer maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance.

Standard IX—Subcontractual Relationships and Delegation

- All RAEs were found to be missing language in the submitted agreements and must ensure, via revision or amendment, that all subcontractor agreements include the following language:
  - The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
- Two of the RAEs were unaware of the status of delegated agreements and were unable to describe the processes that address corrective action plans (CAPs) about subcontractor performance. RAEs must maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight of all agreements (e.g., by the legal department) and developing processes (e.g., a desktop procedure or policy) that address CAPs about subcontractor performance.
- HSAG found that four of the RAEs did not include delegated activities and/or obligations and related reporting responsibilities within their agreements. The RAEs must ensure that all contracts specify delegated activities and/or obligations and related reporting responsibilities.

Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems

- HSAG did not identify any required actions related to QAPI, Clinical Practice Guidelines, and Health Information Systems.