COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Accountable Care Collaborative Regional Accountable Entity Compliance Review Aggregate Report

June 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

The purpose of this report is to summarize the compliance monitoring review scores, strengths, and recommendations for the Regional Accountable Entities (RAEs). Four standards were reviewed in fiscal year (FY) 2024–2025:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing
- Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

While the scores of the individual standards reviewed in FY 2024–2025 ranged from 86 percent to 100 percent among the RAEs, the aggregate scores for these standards were between 94 percent and 100 percent, indicating a strong overall understanding of the four standards reviewed. Specifically, for Standard III—Coordination and Continuity of Care, HSAG found that all RAEs scored 100 percent, resulting in an improved aggregate score compared with the prior review. Consistent with the prior review of Standard IV—Member Rights, Protections, and Confidentiality, the RAEs scored 100 percent, indicating a strong understanding of member rights. For Standard VIII—Credentialing and Recredentialing, five out of the seven RAEs' scores declined from the prior review, but ultimately the aggregate score remained above 90 percent. Lastly, some RAEs' scores declined from the prior review of Standard XI—EPSDT Services, but ultimately the aggregate score increased overall.

2. Overview

Background

The Colorado Department of Health Care Policy & Financing (the Department) implemented the Accountable Care Collaborative (ACC) program in 2011 as a central part of its plan for Health First Colorado (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 for 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 the 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 November 2024 and January 2025, HSAG performed a review described in the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023,[1] 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 III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing
- Standard XI—EPSDT Services

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 3—Statewide Summary of Results includes a comparison of RAE performance based on aggregated compliance scores with federal and State managed care requirements. Section 4—Summary of Strengths and Recommendations includes HSAG's conclusions and overall observations, recommendations, and required actions related to statewide trends.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: May 21, 2025.

3. Statewide Summary of Results

Summary of Compliance With Managed Care Regulations

For the FY 2024–2025 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements: Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VIII—Credentialing and Recredentialing; and Standard XI—EPSDT Services. 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 FY 2024–2025

Table 3-1 presents comparative RAE scores aggregated for all standards reviewed in FY 2024–2025.

Table 3-1—Summary of FY 2024–2025 Total Scores

RAE	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
RAE 1	56	55	53	2	0	1	96%
RAE 2	56	55	55	0	0	1	100%
RAE 3	56	55	53	2	0	1	96%
RAE 4	56	55	55	0	0	1	100%
RAE 5	56	55	53	2	0	1	96%
RAE 6	56	55	54	1	0	1	96%
RAE 7	56	55	54	1	0	1	96%
Total	**392**	**385**	**377**	**8**	**0**	**7**	**98%**

Note: Green shading indicates above 90 percent compliance.

The compliance monitoring review included 56 elements across four standards. Total scores for the RAEs were high (at or above 90 percent) and ranged from 96 percent to 100 percent, demonstrating a strong understanding of the regulations.

Statewide Summary of RAE Compliance Scores by Standard Over Three Years

Table 3-2 presents comparative RAE scores for all standards reviewed from FY 2022–2023 through FY 2024–2025.

Table 3-2—Summary of Statewide Standards From FY 2022–2023 to FY 2024–2025

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 (2024–2025)*	**100%~**	**100%~**	**100%~**	**100%~**	**100%~**	**100%^**	**100%^**	**100%^**
Standard IV—Member Rights, Protections, and Confidentiality (2024–2025)*	**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 (2024–2025)*	**97%v**	**100%^**	**97%v**	**100%^**	**97%v**	**97%v**	**97%v**	**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—EPSDT Services (2024–2025)*	**86%v**	**100%^**	**86%v**	**100%^**	**86%v**	**100%~**	**100%~**	**94%^**
Standard XII—Enrollment and Disenrollment (2022–2023)	100%	100%	100%	100%	100%	100%	100%	100%

* Bold text indicates standards that HSAG reviewed during FY 2024–2025. 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 review three years prior.

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

Of the four standards reviewed in FY 2024–2025, the RAEs demonstrated their greatest strength with both Standard III—Coordination and Continuity of Care and Standard V—Member Rights, Protections, and Confidentiality, as all RAEs achieved 100 percent for these standards. Although five of the RAEs' scores decreased compared with the previous review year for Standard VIII—Credentialing and Recredentialing, two of the RAEs scored 100 percent and the aggregate score was 98 percent. For Standard XI—EPSDT Services, the lowest scoring standard in FY 2024–2025, the RAEs received an aggregate score of 94 percent; however, that score was an increase from the prior review of this standard. An overview of compliance scores from previous years can be found in the FY 2023–2024 External Quality Review Technical Report for Health First Colorado, and further analysis across standards will be presented in the FY 2024–2025 External Quality Review Technical Report for Health First Colorado, scheduled to be released in January 2026.

4. Summary of Strengths and Recommendations

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the strengths and opportunities for improvement for the MCEs in each of the domains of quality, timeliness, and access to care and services. In this report the icons indicate that the strength or opportunity for improvement is related to the associated domain.

Quality

CMS defines "quality" in the final rule at 42 Code of Federal Regulations (CFR) §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO [managed care organization], PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[1]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCE—e.g., processing appeals and providing timely care.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[3]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

HSAG noted the following trends related to strengths, recommendations, opportunities for improvement, and required actions for the four standards reviewed in FY 2024–2025.

Summary of Strengths

Standard III—Coordination and Continuity of Care

- All RAEs supported members with a team of care coordinators and care managers for smooth transitions from different healthcare settings.
- One RAE reported updating its external stratification models.
- Some RAEs provided members with the care coordinator's contact information through a letter.
- The RAEs described efforts to address the needs of specific populations, including individuals with intellectual and developmental disabilities, those with substance use disorders, and individuals transitioning from incarceration.
- Two out of seven RAEs described processes for monitoring providers and contracted care coordination entities through biannual audits to ensure they are adequately providing care coordination.
- Generally, all RAEs used self-referrals, provider referrals, utilization management data, condition management programs, health needs assessments, and population-based triggers to identify members who could benefit from care coordination.

Standard IV—Member Rights, Protections, and Confidentiality

- HSAG identified no strengths related to member rights, protections, and confidentiality.

Standard VIII—Credentialing and Recredentialing

- Some RAEs described how member grievances, adverse events, and quality of care concerns were integrated into the credentialing committee review and decision process.
- As an additional step, two RAEs required credentialing committee members to complete nondiscrimination attestations annually to ensure nondiscrimination practices.

Standard XI—EPSDT Services

- One RAE deployed multiple outreach attempts, considering additional opportunities for children involved with child welfare or those transitioning from residential treatment facilities.
- One RAE used the American Academy of Pediatrics to detect gaps in care and early identification of developmental delays.

- Through their EPSDT programs, the RAEs ensured covered access to well-child, preventive, dental, vision, hearing, behavioral health, developmental, and specialty services. In addition, two RAEs provided medically necessary services at no cost, even if not standard benefits.
- Some RAEs reported that EPSDT procedures and accessible information were available to staff members via trainings, the website, and materials.
- The RAE policies and procedures outlined procedures to refer members to Title V programs for needed additional support such as Head Start; the Women, Infants, and Children (WIC) nutrition program; and early intervention services.

Recommendations and Opportunities for Improvement

Standard III—Coordination and Continuity of Care

- HSAG identified no recommendations or opportunities for improvement related to coordination and continuity of care.

Standard IV—Member Rights, Protections, and Confidentiality

- HSAG identified no recommendations or opportunities for improvement related to member rights, protections, and confidentiality.

Standard VIII—Credentialing and Recredentialing

- HSAG recommended that one RAE review its delegated credentialing organization audit results within its Delegated Oversight Committee to ensure a governance-level monitoring of risk, controls, and compliance.

Standard XI—EPSDT Services

- HSAG recommended that two RAEs implement a refresher course, desktop procedure, checklist, or similar item to ensure all utilization management staff members are appropriately informed about EPSDT services and can ensure consistent application of EPSDT medical necessity requirements and referral practices.
- For two RAEs, HSAG recommended using the first-class mail rate as an intervention to determine the rate of returned mail due to bad addresses.
- HSAG recommended that the RAEs consider engaging the EPSDT population when recruiting for the Member Advisory Committee and consider EPSDT materials when developing an agenda for upcoming review cycles.

- HSAG recommended that the RAEs recruit Spanish-speaking members to review and provide feedback on Spanish language EPDST correspondence to solicit feedback and ensure ease of understanding. 

Required Action Trends

Standard III—Coordination and Continuity of Care

- HSAG identified no required actions related to coordination and continuity of care.

Standard IV—Member Rights, Protections, and Confidentiality

- HSAG identified no required actions related to member rights, protections, and confidentiality.

Standard VIII—Credentialing and Recredentialing

- Five out of seven RAEs did not include policies and procedures for selection and retention on their public websites and must post their policies and procedures publicly on their websites, as required by the RAE contract.

Standard XI—EPSDT Services

- Three of the RAEs did not demonstrate how EPSDT service information and updates were made available to network providers every six months. These RAEs must ensure trainings and updates on EPSDT are provided to network providers every six months.