COLORADO
Department of Health Care Policy & Financing

Annual Quality Report

Instructions and Narrative Report

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RAE/MCO Region: 3
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Purpose: Managed Care Entities (MCEs) are responsible for a variety of quality improvement initiatives as part of the Accountable Care Collaborative (ACC) program. These initiatives are outlined in their quality improvement plan that was submitted in July 2025. This report outlines the MCE's efforts to implement this plan over the previous fiscal year (FY) and/or calendar year (CY), the results of those efforts, and changes to their approach.

Instructions: In the narrative section below summarize your MCE's approach quality work. Describe updates to the quality improvement plan which was submitted at the beginning of ACC Phase III (July 2025). This should also include summarizing the identifications and use of quality metrics and data that the MCE tracks that are not provided by Health Care Policy and Financing (HCPF). Additionally, these sections should include a summary of the MCE's approach, success, challenges and updates to the approach. Each section should be 1-2 pages long. Please use concise language in your response, the Department suggested length for the narrative portion is approximately twenty (20) to twenty-five (25) pages. The deliverable includes an accompanying data workbook for reporting a number of quality projects. Please complete the workbook according to the instructions and include with the deliverable submission.

Applicable to all MCEs

1. **Summary of your overall quality approach**

    a. Provide a brief summary of your MCE's approach to quality improvement. Describe your quality goals or priorities for FY 25-26, how data was used to identify improvement opportunities and monitor progress, and what tools you currently use. Include how you incorporated your internal and external committee meetings that were shared in your Quality Improvement (QI) plan to report out and elicit feedback on your quality improvement efforts.

Colorado Community Health Alliance's (CCHA) Quality Improvement Program provides an integrated framework for monitoring and improving the quality, safety, accessibility, and member experience of services provided to Health First Colorado members. The program integrates physical and behavioral health, population health,

care coordination, provider performance, member experience, and Healthy Colorado For All strategies within a continuous cycle of measurement, analysis, intervention, monitoring, and stakeholder feedback.

During SFY25-26, CCHA prioritized implementation of Healthcare Effectiveness Data and Information Set (HEDIS) measurement year reporting aligned with HCPF specifications; improvement in behavioral health member experience through surveys, outreach, and Comprehensive Safety Net Provider (CSNP) value-based purchasing; timely resolution and reporting of Quality of Care Grievances (QOCGs); and designing the clinical 7-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA7) HEDIS and nonclinical Transitions of Care Performance Improvement Projects (PIPs). These priorities were informed by contractual requirements, evidence-based standards, external quality review findings, and identified member, provider, and regional needs.

CCHA used quantitative and qualitative data to identify improvement opportunities, monitor interventions, and evaluate results. Performance was trended over time and, when applicable, compared with HCPF goals, national benchmarks, prior year results, regional performance, and provider-level results. HCPF-provided data were supplemented with administrative and utilization data; clinical, care management, and provider information; HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and external quality review results; member surveys, grievances, and quality of care concerns; provider performance data; and population health and predictive analytics. Together, these sources provided multiple signals of member health, access, utilization, outcomes, safety, experience, and provider performance.

Internally generated data provided timely opportunities to identify and respond to concerns. CCHA's Behavioral Health Post-Visit Survey captured member experience with access, timeliness, providers, and overall care soon after services were received. Members reporting actionable health care needs were contacted for assistance, while de-identified provider-level findings supported improvement and accountability through CCHA's value-based purchasing arrangements. Care Coordination and Post-Call surveys informed staff education and workflow improvements, and grievance and QOCG trends were monitored for recurring concerns, patient safety issues, and provider-specific patterns.

CCHA also stratified selected measures by characteristics such as county, language, race and ethnicity, age, gender, and disability status to identify performance differences and contributing barriers. Population health and predictive analytics identified higher-risk members and patterns of utilization or unmet need to inform outreach, care coordination, and other interventions. Findings from these analyses informed quality improvement activities, with subsequent performance monitored to assess effectiveness.

CCHA uses business intelligence, quality measurement, operational tracking, and population health tools to support this work. Key capabilities include Power BI and Tableau for visualization; Teradata, Structured Query Language (SQL), Python, and internal data warehouses for analytics; National Committee for Quality Assurance (NCQA) certified HEDIS software and Quality Spectrum Insight for quality measurement; Pega Business Objects for grievance and QOCG tracking; and the Chronic Illness Intensity Index and Whole Health Analytics dashboard for risk stratification and population health analysis.

CCHA's internal and external governance structure provides oversight, accountability, and stakeholder input into quality improvement. The Quality Improvement Committee (QIC) serves as the primary internal forum for oversight of the annual QI Plan, bringing together senior leadership and clinical, operational, quality, compliance, population health, and Healthy Colorado For All functions to review performance and inform prioritization, operational changes, and refinements to interventions.

External perspectives are incorporated through regional Program Improvement Advisory Committees (PIAC), the Healthy Colorado for All Committee (HCAC), Member Advisory Committees (MAC), provider engagement activities, and HCPF-led statewide forums. Members, caregivers, providers, community organizations, and advocates provide input on program design, proposed initiatives, member-facing materials, barriers, and improvement opportunities to support alignment with the needs and preferences of the populations served. Notably, MAC feedback informed adjustments to CCHA's Healthy Rewards incentive program, including the portfolio of eligible activities and reward amounts, to strengthen alignment with member preferences and intended motivational impact.

Provider surveys, coaching, performance feedback, and recurring collaboratives provided additional input into improvement strategies. CCHA also participated in statewide operational, data, behavioral health, leadership, and learning collaborative forums with HCPF and other MCEs to review performance, clarify requirements, and exchange promising practices.

These mechanisms create a structured feedback loop in which CCHA monitors multiple signals of care, identifies risks and opportunities, translates findings into action, reassesses performance, and incorporates member, provider, community, and State perspectives into ongoing quality improvement.

2. Updates to your plan

a. Please describe any modifications made to your Quality Improvement Plan during the reporting period, including the rationale for the change and the implementation date. Your description must include the plan's selected clinical and nonclinical ACC Phase III Performance Improvement Projects.

   Your description can also include updates regarding:

- Your MCE's quality goals or priorities for FY 26-27
- Any tools planned to be used for FY 26-27
- Internal and external committee meetings that will support your organization's quality improvement efforts in FY 26-27

Updates to the SFY25-26 Quality Improvement Plan

CCHA's overall QI strategy remained materially consistent with the SFY25-26 Quality Improvement Plan. During the reporting period, CCHA updated the plan to reflect evolving Department guidance and program requirements, including modifications to Primary Care Medical Provider (PCMP) and Regional Accountable Entity (RAE) incentive programming, the PIPs and Behavioral Health Incentive Program (BHIP) measures, and enhancements to member experience measurement, member engagement strategies, and advisory committee structure.

Performance Improvement Projects

Clinical PIP: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 Days (FUA7)

The State-selected clinical PIP remained focused on improving 7-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA7). The SFY25-26 QI Plan reflected initial guidance identifying members age 18 years and older as the target population. During study design, CCHA expanded the population to members age 13 years and older, consistent with HEDIS specifications and population differences identified in the CY2024 Health Equity dataset.

CCHA's NCQA-certified vendor calculated a CY2025 pre-baseline rate of 28.08%, with 781 of 2,781 eligible emergency department (ED) visits receiving follow-up within seven days. During SFY25-26, CCHA defined the study methodology and validated the data sources and quality indicators needed for performance measurement.

The QI Plan anticipated statistically significant improvement over baseline by December 31, 2026. HCPF subsequently established CY2026 as the baseline and design year, with interventions beginning January 1, 2027 and Remeasurement 1 ending December 31, 2027. CCHA aligned our goal accordingly, targeting statistically significant improvement over the CY2026 baseline by the end of Remeasurement 1.

Nonclinical PIP: Transitions of Care (TOC)

The SFY25-26 QI Plan identified Screening for Social Drivers of Health (SDOH) as the State-selected nonclinical PIP topic. Following plan submission, HCPF revised the framework and directed RAEs to develop nonclinical PIPs addressing administrative, operational, or support processes affecting behavioral health transitions of care.

CCHA's Transitions of Care PIP aims to increase the percentage of behavioral health discharge notifications received within two calendar days of discharge. Because the measure was newly developed, no pre-baseline data is available. During SFY25-26, CCHA defined the study population and specifications, assessed existing workflows, and developed and validated the data sources required for measurement. Consistent with the revised timeline, CY2026 serves as the baseline and design year, with

statistically significant improvement over baseline targeted by the end of Remeasurement 1 on December 31, 2027.

Behavioral Health Incentive Program (BHIP)

The SFY25-26 QI Plan reflected the State-established BHIP measure set in effect at the time of submission. During SFY25-26, HCPF replaced SDOH with a two-part Screening for Depression and Follow-Up measure for adults and children, with both components required to earn the associated incentive. CCHA incorporated the revised measure into BHIP performance monitoring and provider engagement activities. The remaining measures were unchanged.

New Primary Care Post-Visit Survey

CCHA is expanding member experience measurement through development of a post-visit survey for members receiving primary care services. Modeled after CCHA's behavioral health post-visit survey, this expansion will provide a timelier source of member experience information for medical services to inform future quality improvement activities.

Advisory Committees

CCHA is refining our advisory committee structure to strengthen representation and active participation. First, the Regional Health Equity Committee (RHEC) was renamed the Healthy Colorado for All Committee (HCAC) during SFY25-26 to align with State nomenclature. Second, CCHA is developing a recruitment and outreach strategy for PIAC North and South, as well as HCAC as we want to ensure the right stakeholders are present during the most impactful discussions. Lastly, in SFY26-27, CCHA will transition from English- and Spanish-language MAC to three forums: a rural MAC beginning with Park County, a virtual Spanish-language MAC primarily serving El Paso County, and an English-language MAC for long-standing CCHA members. Participation criteria and engagement processes are also being strengthened to promote consistent, meaningful member contribution. Committee input will continue to inform process development and strategies supporting coordinated, patient-centered care that reflects the needs of Health First Colorado members.

3. Underutilization and Overutilization of Services

a. Summarize underutilization and overutilization of services identified during the reporting period FY25-26. Assess the effectiveness of the mechanisms implemented to identify, monitor, and address underutilization and overutilization of services. Describe key findings and trends, actions taken to address identified issues, resulting improvements, successes, challenges, barriers, and future plans. There is no associated workbook tab for this topic.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Update

CCHA's EPSDT Program continues to operate as a cross-functional effort, with Clinical Quality, Utilization Management (UM), and Member Engagement. CCHA continues EPSDT outreach to new members and non-utilizers, while PCMPs receive ongoing notifications for members past-due for EPSDT services, updated screening timelines

aligned with American Academy of Pediatrics' (AAP) Bright Futures recommendations, and toolkits upon request.

Access and Availability Monitoring Update

CCHA's Practice Success team continues quarterly collection of third next available appointment (3NA) data from PCMPs to assess and confirm network timeliness for urgent care, non-symptomatic care, and well-care visits. As a national access-to-care measure, 3NA measures the third rather than the next available appointment, filtering out one-off cancellations for a more accurate access picture.

Underutilization and Overutilization of Services – SFY25-26

CCHA monitored underutilization through the preventive health performance measure set, including cancer screenings, childhood and adolescent immunizations, well-child visits, developmental screening, prenatal/postpartum care, depression screening, and dental evaluation, and overutilization was monitored through the statewide Client Overutilization Program (COUP).

Key Findings and Trends

Underutilization was most pronounced in childhood and adolescent immunizations. Childhood Immunization Status, Combination 10 declined from 24.93% to 17.93%, falling further below the Basecamp threshold of 27%. Immunizations for Adolescents, Combination 2 declined from 26.99% to 24.35%, also below the 31% Basecamp threshold. Well-Child Visits (15th-30th Months) improved slightly, from 67.83% to 69.79%, but remained under the 72% Basecamp threshold. Cancer screening showed minimal movement: Breast Cancer Screening rose from 36.39% to 37.81% (38% threshold), and Cervical Cancer Screening was flat at 46.06% (47% threshold). Dental Oral Evaluation declined from 48.89% to 46.17%.

By contrast, Prenatal and Postpartum Care (Postpartum Care) improved from 67.40% to 74.14%, a 6.7-point gain that crossed the Basecamp threshold, and Colorectal Cancer Screening improved from 29.84% to 34.90%, also crossing the Basecamp threshold. Developmental Screening in the First Three Years of Life and Screening for Depression and Follow-Up (Adult) remained well above their Summit and Treeline thresholds, respectively, indicating no utilization concern in those areas.

For overutilization, CCHA receives a quarterly HCPF list identifying members who overutilized pharmacy and ED services under COUP, which CCHA uses to prioritize targeted outreach, care coordination, and PCMP selection support. We also monitor stratified readmission rates to identify populations and conditions that could benefit from additional condition management support through our internal Care Coordination team in conjunction with regular visits with a PCMP.

Effectiveness of Monitoring Mechanisms

For underutilization, the quarterly Gaps in Care report and Member-Level Drill Down flag members who met the denominator but not the numerator for a given measure,

allowing PCMPs to prioritize outreach and scheduling. This mechanism proved effective where measure performance improved (Postpartum Care and Colorectal Cancer Screening), but did not prevent childhood and adolescent immunization rate declines, indicating that changing public sentiment and PCMP-level follow-through remain a challenge.

For overutilization, the COUP list gives a reliable, standardized way to identify overutilizing members. CCHA outreaches these members through two interactive voice response (IVR) call campaigns per reporting period, with an option to connect with CCHA's call center for further support. This provides consistent identification and outreach cadence, though as an IVR-based approach it depends on member responsiveness, which may limit engagement for members with more complex needs.

Readmission data analyses identified elevated readmission rates among members in rural counties with hypertension and/or diabetes diagnoses. In response, we partnered with rural community organizations to identify unattributed members with these diagnoses and connect them to a PCMP. One example is our work through the Colorado Health Innovation Community (CHIC) cohort, described below.

Successes and Actions Taken

For underutilization, targeted outreach and care coordination tied to postpartum care and Colorectal Cancer Screening were the most plausible drivers behind both measures crossing their Basecamp thresholds this period, the clearest successes of the year. Developmental Screening and Adult Depression Screening also sustained strong, above-threshold performance throughout.

For overutilization, CCHA conducted two IVR call campaigns during the period, ensuring every member flagged by HCPF for pharmacy or ED overutilization received at least two outreach attempts and a standing offer of call center support and PCMP selection guidance, consistent with COUP's goal of directing overutilizing members to more appropriate care pathways.

Preliminary results of efforts to reduce readmissions show increased attribution among members who worked with local partners to identify a PCMP. Future analyses will assess whether the intervention favorably impacts readmission rates.

Challenges and Barriers

Declining childhood and adolescent immunization rates, despite active monitoring and driven partly by changing federal guidance, contributing to member confusion and resistance toward full AAP schedules, are the reporting period’s most significant challenges. Breast and Cervical Cancer Screening rates remain flat and just under threshold, suggesting current interventions have not yet produced meaningful movement. For overutilization, the COUP program's reliance on an IVR outreach model means member engagement is dependent on response to automated calls, and

members who do not engage with the IVR campaigns or opt into call center support may not receive further follow-up within the reporting period.

Future Plans

Planned next steps include member communications about the importance of following AAP immunization guidelines, renewed PCMP-level gap outreach for well-child visits and cancer screenings given their proximity to threshold, and continued quarterly COUP IVR outreach campaigns, with consideration of supplemental outreach channels for members who do not respond to IVR contact, to strengthen engagement among members identified for pharmacy and ED overutilization.

4. **Quality and Appropriateness of Care for Members with Special Health Care Needs.**

    a. Summarize activities during the reporting period related to assessing the quality and appropriateness of care furnished to members with special health care needs, as defined by the Department for FY 25-26. Assess the effectiveness of the mechanisms used to evaluate quality and appropriateness of care, and describe key findings, actions taken in response to identified issues, resulting improvements, successes, challenges, barriers, and future plans. There is no associated workbook tab for this topic.

CCHA considers members to have special health care needs when they have, or are at increased risk for having, chronic, physical, developmental, behavioral, or emotional conditions that require health and related services beyond the norm. We focused on two populations: members co-managed with Case management Agencies (CMAs) and members with justice-involvement. We applied our Healthy Colorado For All approach across the full population.

CMAs

Successes

CCHA maintains close partnerships with CMAs, including monthly complex case reviews, established workflows, memoranda of understanding (MOUs), data-sharing agreements, and ad hoc training. CCHA currently holds MOUs and/or data-sharing agreements with The Resource Exchange (TRE), A&I Avenues, Developmental Pathways, Rocky Mountain Human Services (RMHS), Foothills Gateway, and Otero County Department of Human Services. These partnerships have produced several positive outcomes, including increased member and family satisfaction through more effective collaboration and communication on service plans and benefits, reduced case management tenure, and accelerated historically delayed processes, and protected coverage through more effective recertification support. The high volume of referrals CCHA receives reflects strong utilization of the partnership to reduce barriers to care and help members navigate the healthcare system. CCHA continues to participate in the RAE/CMA Forum, supporting ongoing collaboration and alignment.

Future Plans

Jefferson County CMA, a covered entity without a formal MOU in Phase III, has recently expressed renewed interest, and CCHA is working to finalize an agreement that will formalize this existing collaborative relationship. CCHA will also continue to build on outcomes from our CMA partnerships and the RAE/CMA Forum to further reduce case management tenure, streamline recertification support, and strengthen coordination for members shared with CMA partners.

Justice-Involved

CCHA receives two rosters related to justice-involved members: a weekly Department of Corrections (DOC) roster of members scheduled to release from prison and reenter CCHA's service area, and a monthly Judicial Branch roster of members assigned to Probation in one of our eight counties. In SFY25-26, 474 members were listed on the DOC roster (220 released to El Paso County) and 165 members on the Judicial roster (133 reporting to 4th Judicial District's Probation in El Paso County). El Paso County's higher conviction rate drives both trends, while the 4th Judicial District's (Teller and El Paso) stronger Probation Officer engagement leads more members to complete a release of information to be placed on the Judicial roster.

Successes

Ascent Health, a collaborative partner receiving CCHA's DOC roster, engages members by phone to encourage them to participate in a behavioral health (BH) encounter, supporting the DOC BH Key Performance Indicator (KPI) through education on Medicaid benefits, offering services, and referrals if a member prefers a different provider. Ascent engaged with nearly 50% of DOC roster members in SFY25-26, indicating the outreach model is effectively reaching a substantial share of this hard-to-contact population, despite ongoing barriers such as unpredictable release dates, inaccurate contact information, and competing priorities upon release.

Future Plans

CCHA and Ascent are reviewing a program evaluation plan, aided by Ascent's recently upgraded electronic health record (EHR) system, to more directly assess impact on BH outcomes. For the Judicial roster, CCHA is building a Power BI dashboard to track member utilization and drive strategy and interventions toward appropriate, preventive health care services.

Healthy Colorado For All

Successes

During SFY25–26, CCHA developed our ACC Phase III Healthy Colorado For All strategic plan, a seven-year strategy focused on closing gaps in care for members, including those with special health care needs. The plan was informed by an analysis HCPF data across race, ethnicity, gender, language, disability status, and geography, using statistical methods such as odds ratios and chi-square tests, supplemented by literature and evidence-based research given known limitations in self-reported and

enrollment data. We identified populations and geographic areas with unmet needs across preventive, behavioral health, maternity/perinatal, and prevention and wellness measures, and identified interventions to target. Findings were shared with the MAC and Regional HCAC, leveraging this stakeholder engagement structure to inform QI priorities. CCHA also achieved success through the Colorado Health Innovation Community (CHIC) cohort with Prime Health, partnering with Aspen Mine Center (AMC) to improve primary care access for Medicaid members in Teller County with hypertension and/or diabetes. The pilot has already met its goal of increasing PCMP attribution among this population from 88% to 93% by October 2026.

Future Plans

CCHA will continue implementing planned interventions, including targeted outreach, improved language access (bilingual messaging, interpreter workflows and Spanish-language campaigns), expanded engagement (telehealth, AI-driven texting, phone outreach, and home visits), and collaboration with local public health agencies when appropriate. Ongoing challenges include demographic data limitations and detecting health care gaps in smaller populations. CCHA will continue monitoring data, refining populations of focus, and evaluating interventions to improve access, quality, and outcomes for all members, including those with special health care needs.

5. External Quality Review Organization (EQRO) Compliance (Summary): Fiscal Year reporting period

a. Summarize the results of the EQRO compliance efforts for FY 25-26. Include the standards reviewed that require a Corrective Action Plan (CAP). Describe key compliance successes, challenges encountered, and actions taken to address identified findings. Additionally, outline future plans and priorities for maintaining and improving compliance performance.

Annual Compliance Audit

During SFY25–26, Health Services Advisory Group (HSAG), evaluated CCHA's compliance with four standards: Standard I—Disenrollment: Requirements and Limitations; Standard IV—Availability and Assurances of Adequate Capacity and Services; Standard VII—Coverage and Authorization of Services; and Standard X—Grievance and Appeal Systems. CCHA achieved an overall compliance score of 91%.

CCHA demonstrated strong compliance success in enrollment and disenrollment processes, network adequacy and access, culturally competent services, authorization decision-making, and appeal timeliness. HSAG identified no required corrective actions for Standards I or IV. Corrective Action Plans (CAPs) were required for Standards VII and X, primarily related to member notices and grievance processes and are underway.

Within Standard VII, findings involved denials that did not generate the required Notice of Adverse Benefit Determination (NoABD), clarity and completeness of NoABD language, and documentation of all six American Society of Addiction Medicine (ASAM)

dimensions in applicable substance use disorder (SUD) NoABDs. CCHA's corrective actions include revised NoABD workflows and audit tools, staff and Medical Director education, leadership review of NoABDs, monthly peer auditing, and system configuration changes to strengthen notice generation and content.

Within Standard X, findings focused primarily on grievance identification, appropriate clinical review, required grievance resolution content, member-friendly correspondence, and appeal notice clarity. CCHA has recognized the challenge of tracking the grievances of members who report grievances (defined partially as “any expression of dissatisfaction”) that are resolved within the one phone call that the member is making to our Member Support Services representatives. CCHA initiated the multidisciplinary "One Call, One Solution" effort to ensure all expressions of dissatisfaction are appropriately recognized and tracked as grievances. CCHA delivered targeted training to ensure staff understand that grievances must be recorded and tracked regardless of whether member consent is obtained. CCHA also strengthened other areas of training, clinical routing, correspondence standards, audit processes, and quality controls. Corrective actions for appeal notices similarly address plain language, required taglines, appropriate enclosures, and template controls.

Going forward, CCHA's priority is to sustain areas of full compliance while strengthening oversight of member-facing authorization, grievance, and appeal processes. CCHA will continue implementing CAP activities, monitoring NoABD and grievance/appeal correspondence, conducting recurring audits, and using results to identify trends and initiate corrective coaching, retraining, workflow changes, or system improvements when necessary. These efforts are intended to demonstrate completion of the current CAP requirements while establishing sustainable controls that support continued regulatory compliance and protection of member rights.

411 Audit Quality Improvement Plan (QUIP)

Findings from the SFY24-25 Behavioral Health Encounter Data Quality Review (411 Audit) identified psychotherapy documentation accuracy below the 90% compliance threshold for procedure code (85%), place of service (76%), and service category modifier (72%). CCHA partnered with the pilot provider to implement targeted interventions addressing elements below the 90% threshold. Intervention effectiveness was evaluated through monthly re-audits of a sample of psychotherapy records rendered by a high-volume CSNP partner over a three-month period.

The re-audits demonstrated measurable improvement and sustained performance for most audited elements. The reviews also identified additional failure modes that were not observed during the initial audit, indicating that further process controls were needed to achieve comprehensive compliance. Interventions implemented during the QUIP were maintained, and reliable workflow-embedded solutions are being developed and tested to resolve newly identified vulnerabilities. Because the provider did not achieve at least 90% accuracy across required elements by the end of

the QUIP, CCHA will continue periodic auditing and targeted oversight until accuracy rates consistently meet or exceed the threshold for at least two consecutive quarters

Following State directives, the Encounter Data Quality Review was not conducted in SFY25-26. CCHA has maintained ongoing processes for monitoring, investigations, provider education, targeted provider feedback, and system controls to reinforce BH coding and documentation requirements and support accurate encounter submissions.

Inpatient and Residential SUD Service Denial Determination

During SFY25-26, HSAG reviewed Inpatient and Residential SUD Service Denial Determinations for the two regions CCHA served under the ACC Phase II contract structure, Region 6 and Region 7, now consolidated as Region 3 under ACC Phase III. Both regions demonstrated several areas of compliance performance. CCHA contacted providers to obtain additional clinical information and utilized extensions when additional time was needed to obtain information or complete the peer-to-peer process. Region 7 demonstrated 100% agreement with HSAG medical necessity determinations. Provider notification timeliness was 96% for both regions, with NoABDs issued to 97% of Region 6 members and 98% of Region 7 members.

HSAG identified incomplete treatment plan documentation for continued stay reviews as a primary compliance opportunity for both regions. Missing treatment plans were identified as a factor in cases where ASAM criteria were not appropriately applied to continued stay determinations. Additional findings included select process and workflow gaps, NoABD timeliness, and documentation of population-specific considerations for older adult members.

In response, CCHA reinforced provider education on treatment plan submission through the monthly behavioral health newsletter and facility meetings. CCHA also updated and re-reviewed SUD workflows with the team to support consistent application. The monthly peer audit tool was updated to monitor denial requirements, including status reasons, ASAM criteria, treatment plan requests, and NoABD timeliness. Leadership reviews NoABDs before distribution, and staff education reinforced documentation for older adult members. CCHA will continue monitoring these areas through provider education, leadership review, and monthly audits.

Mental Health Parity Audit

CCHA received an overall score of 89% on the Mental Health Parity audit. It identified strengths in UM governance, including licensure requirements for first-level UM staff, use of extensions to obtain additional clinical information when needed, and internal review of proposed policy and benefit changes for mental health parity considerations. Opportunities identified included peer-to-peer documentation, NoABD timeliness and consistency, expedited authorization notification time frames, EPSDT documentation, and education regarding prior authorization request (PAR) requirements and exemptions.

In response to these findings, CCHA updated the peer-to-peer, NoABD letter, and EPSDT workflows to address the identified opportunities and re-educated staff on the

revised workflows and requirements. Additionally, the monthly audit tool was updated to ensure staff are meeting the applicable documentation requirements within the workflows. Leaders review NoABD letters prior to issuance to support timeliness and consistency. CCHA also updated provider resources to clarify services that require PAR and applicable exemptions and shared these resources with UM staff and providers. CCHA will continue staff and provider education, leadership review, auditing, and monitoring of the areas identified in the audit.

6. Member Experience: Fiscal Year reporting period

a. Describe efforts to measure and improve the member experience for FY 25-26. Please include:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) information
- Information about other member experience efforts such as additional metrics, survey results, trend data, and performance measures
- Findings/results of member experience efforts
- How findings are shared with providers, members, or stakeholders
- Interventions or changes made as a result of findings.

Provide data that measures those efforts in the data workbook. This tab may include supporting metrics, survey results, trend data, performance measures, and other relevant information that complements the narrative provided in this report.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

This report reflects results from the 2025 measurement year CAHPS Medicaid Health Plan Survey for Region 3 – CCHA. **132 adults** (8.15% completion rate) and **172 children's caregivers** (8.69% completion rate) completed the survey. To determine high and low scores, CCHA used the following criteria:

- **High Score (Top-Box)** – the best possible answer to a question, ex. "Always," a rating of 9 or 10, "Not At All Difficult," "Excellent/Very Good," or "Yes."
- **Opportunity for Improvement (Bottom-Box)** – the worst answers to a question, ex. "Never/Sometimes," a rating of 0–6, "Extremely/Very Difficult," or "Fair/Poor."

Adult Survey Results (n = 132)

Strengths (Top-Box Scores): Respondents rated their personal doctor relationships most positively. 73.1% reported having a personal doctor, 80.3% said their personal doctor always showed respect for what they had to say, 70.0% said their doctor always listened carefully, and 70.4% said they had received care from another provider besides their personal doctor in the last six months.

Opportunities for Improvement (Bottom-Box Scores): The clearest gaps involve tobacco cessation support. 71.9% said their doctor never or only sometimes discussed non-medication strategies for quitting smoking or tobacco use (such as helplines), and

65.6% said the same for medication options (nicotine gum or patches), suggesting this is an area with substantial room for more proactive counseling. Access to timely care is another concern: 31.3% said they never or only sometimes got a specialist appointment as soon as needed, with two related access issues also standing out; 28% cited difficulty getting help from customer service, and 25% cited trouble getting a routine appointment quickly enough. Finally, general health perception was mixed. 29.7% of respondents rated their overall health as fair or poor.

Takeaway: The data point to a consistent theme; personal doctor communication and rapport are strong, while systemic access issues (specialist referrals, routine scheduling, customer service) and preventive counseling (tobacco cessation) represent the clearest opportunities for improvement.

Child Survey Results (n = 172 caregivers)

Strengths (Top-Box Scores): The standout strength for children's care is provider understanding: 96.0% of caregivers said their child's personal doctor understood how medical, behavioral, or other health conditions affect their child's day-to-day life, an exceptionally high score reflecting strong clinical rapport once families are in front of a provider.

Opportunities for Improvement (Bottom-Box Scores):Access outside of standard care fits into a clear pattern: caregivers are generally satisfied with their child's personal doctor, but face consistent friction getting supplementary services and timely appointments. The most significant gap is after-hours access; 58.8% of caregivers said they never or only sometimes could get care for their child during evenings, weekends, or holidays. Getting special medical equipment or devices was also difficult, with 50.0% reporting never or sometimes, and getting therapy for their child was a hurdle for 33.3%. Specialist access lagged as well: 22.4% said they never or only sometimes got a specialist appointment as soon as their child needed one.

Takeaway: As with the adult results, the core doctor-patient relationship is a clear strength; caregivers feel understood and well cared for during direct visits. However, the surrounding support system (after-hours access, equipment, therapy, and specialist referrals) is the clearest and most consistent opportunity for improvement.

Overall Summary

- **Doctors are doing a great job in one-on-one visits**, for both adults and kids. Respect, listening, and time spent with patients all score high.
- **The biggest problem is getting specific services fast.** For adults, that means help quitting smoking and seeing specialists. For kids, that means equipment, therapy, specialists, and after-hours care.
- **Most basic questions were answered by almost everyone.** Lower response counts for follow-up questions are expected, as these questions were asked only of certain respondents. Therefore, the lower volume of responses does not represent a data concern.

CCHA will share these results with PCMPs and work solutions into quality improvement activities where appropriate.

Post-Call Survey (formerly the Member Assistance Survey)

This survey was redesigned partway through the fiscal year to collect data from inbound calls. From July 2025 - March 2026, it asked three questions: whether the caller was helped (84.5% average "yes"), whether staff were friendly (93.4%), and whether the member would reach out to CCHA again in the future (86.9%), with a 14.4% average engagement rate (9,413 surveys launched, 1,357 completed). Starting April 2026, the survey was rebuilt with six questions covering ease of reaching CCHA (79.3%), staff friendliness (81.3%), whether options/resources were reviewed (77.2%), whether next steps were offered (78.5%), overall satisfaction (81.5%), and likelihood to reach out again (84.6%), with a 15.3% engagement rate (3,073 launched, 471 completed). Across both survey versions, CCHA launched 12,486 post-call surveys and completed 1,828 for the fiscal year.

Care Coordination Survey

Members working with CCHA Care Coordination are surveyed via email (Survey Monkey), text, and/or phone transfer, using three questions on a five-point scale: whether their situation is better because of CCHA, whether they can better manage their health, and overall satisfaction. Satisfaction is consistently high (4.3-4.5 of 5 across channels; 81%-93% for individual interactions), though engagement (completion) rates are modest (9%-15%), which limits generalizability. The new phone transfer channel is low volume, so results should be read as directional rather than statistically reliable.

The phone transfer channel was added in November 2025 to capture immediate in-call feedback, and the post-call survey was redesigned in April 2026 to capture more actionable detail. This data plays a key role in CCHA's quality assurance process by guiding targeted coaching, prompting immediate action on serious concerns, and supporting ongoing monitoring to determine whether improvement initiatives are producing measurable results.

Behavioral Health Post-Visit Survey

CCHA continued our monthly BH post-visit survey in CY2025, distributed by text in English and Spanish with the opportunity for open-ended feedback to measure member experience with access, timeliness, providers, and overall care. CCHA received 2,134 completed surveys. Overall experience rating rose from 60% (CY2024) to 66% (CY2025), exceeding the SFY25-26 QI Plan two percentage point improvement goal. The largest gains occurred in ratings of specialists and overall health care. The percentage of members rating their specialist a 9 or 10 rose from 57.3% to 74.2%, while ratings of overall health care at 9 or 10 rose from 48.5% to 65.9%. Results support both member-level and provider-level improvement. Members reporting actionable health care needs are referred for outreach and assistance, while de-identified, provider-specific results are shared with eligible CSNPs through quarterly scorecards and incorporated into CCHA's value-based purchasing approach to support targeted improvement activities. In SFY26-27, CCHA will maintain the BH post-visit survey strategy and will expand post-visit member experience measurement in CY2026 to members receiving primary care services.

7. Performance Improvement Projects (PIP): Previous PIP Cycle

a. Summarize PIP efforts for the previous PIP cycle. Include successes, challenges, lessons learned and future plans. Include specific ACC Phase III PIP pre-baseline measurement results if available in the data workbook portion of the deliverable.

Clinical PIP: Follow-Up After Hospitalization for Mental Illness Within 7 Days (FUH7)

During the previous PIP cycle, CCHA administered separate PIPs for Regions 6 and 7, which are now incorporated into CCHA's Region 3 service area. CCHA tested provider-based interventions designed to strengthen transitions between inpatient and outpatient behavioral health care and improve timely follow-up consistent with the Centers for Medicare & Medicaid Services (CMS) Core Measure specifications for Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7).

The interventions selected supported focused testing and rapid-cycle learning but reached only a portion of the regional population. Participating providers were large enough to influence regional performance but not to independently determine it; therefore, intervention gains could be offset by unrelated performance changes in the network. Although neither region achieved statistically significant improvement in the final regional PIP rate, regional statistical significance and intervention effectiveness represent different levels of evaluation.

The interventions produced measurable provider-level improvements and strengthened transitional care infrastructure. Participating providers standardized discharge and follow-up procedures, improved coordination between inpatient and outpatient settings, and strengthened processes for scheduling and delivering qualifying services. Process-level data also identified documentation and billing issues affecting performance, while greater understanding of FUH7 specifications strengthened providers' ability to monitor and improve results.

Member no-shows and cancellations remained a persistent barrier to completed follow-up. CCHA encouraged participating providers to leverage the Healthy Rewards member incentive program to promote engagement in recommended aftercare; however, utilization has not been sufficient to determine the effectiveness of incentives in improving attendance.

The cycle also demonstrated the operational complexity of developing cross-organizational workflows while simultaneously measuring performance. This limited the time available for interventions to reach stable operation and demonstrate measurable impact. Using a FY measurement period created challenges for a HEDIS-based measure because it did not align with the standard CY measurement cycle.

The following PIP cycle includes structural changes that provide additional opportunities to address these challenges. HCPF aligned PIP measurement with the HEDIS calendar year and established a dedicated design period before intervention

implementation. CCHA will use this preparation period to establish and validate workflows and data infrastructure before measurement begins and will aim to pursue interventions with sufficient operational readiness, reach, and ability to influence measured performance.

Nonclinical PIP: Social Drivers of Health (SDOH) Screening

During the previous PIP cycle, CCHA administered separate SDOH PIPs for Regions 6 and 7. The State-mandated PIP topic focused on increasing screening for unmet food, housing, utility, and transportation needs. CCHA targeted members transitioning from higher levels of behavioral health care through our Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) programs. Focusing quality improvement efforts on members with a recent history of high acuity needs, such as those discharged from inpatient psychiatric hospitals and residential/inpatient SUD treatment, aimed to address unmet social needs that affect their ability to engage with preventative and lower-intensity services.

Because the intervention was implemented directly within CCHA's operations, Quality and Care Coordination teams were able to closely monitor performance, obtain direct staff feedback, and make timely workflow adjustments. Key enhancements included embedding a standardized SDOH tool within the Health Needs Assessment, implementing performance tracking, providing targeted staff education, auditing assessments before case closure, and reviewing results with Care Coordinators.

Testing identified inconsistent use of standardized screening questions and the length of the comprehensive assessment as primary barriers. CCHA responded by clarifying required elements, reinforcing standardized screening and documentation expectations, providing staff-specific performance feedback, and implementing pre-closure audits that enabled real-time correction and coaching. Staff participation in workgroups also supported practical workflow improvements and increased ownership of results.

These changes produced sustained improvement, and both regions achieved statistically significant improvement over baseline in the overall PIP measure. The PIP demonstrated the value of embedding quality improvement within operational workflows and using timely process data and staff feedback to identify and address implementation gaps. CCHA's ability to access the systems where screening was documented, engage directly with the staff performing the work, and adjust workflow, training, and oversight processes supported rapid-cycle improvement and greater process stability. The experience also reinforced that standardized tools must balance measurement consistency with usability and the practical demands of member engagement.

The integration of standardized SDOH screening embedded in assessment forms was deemed effective and was adopted, with subsequent workflow refinements intended

to reduce administrative burden while preserving identification of priority social needs and connection to appropriate resources.

8. Quality of Care Grievances (QOCGs): Fiscal Year reporting period

a. Describe overall QOCG trends that were identified during the FY 25-26 reporting period. Include an analysis of notable patterns, emerging issues, and a summary of the top five QOCG subcategories reported during the fiscal year. Discuss any actions taken to address identified trends and opportunities for improvement based on FY 25-26 HSAG QOCG audit findings. There is no associated workbook tab for this topic.

During SFY25-26, CCHA reviewed 70 QOCG referrals, a 12% increase from the prior year. Quarterly volume remained relatively stable, ranging from 17 to 19 referrals, with a modest increase in the fourth quarter. CCHA achieved our SFY25-26 timeliness goal, resolving 100% of QOCGs within 90 calendar days, exceeding the 90% target.

CCHA trended QOCGs by issue type and severity to identify recurring concerns, potential safety risks, and opportunities for provider or system-level improvement. Among the 70 cases reflected in the severity analysis, suicide attempt requiring significant medical intervention was the most frequently reported subcategory, with 12 cases, followed by self-harm requiring significant medical intervention with eight cases. The top five subcategories were completed by a four-way tie at five cases each: allegations of abuse, neglect, or exploitation; death with unknown cause; medication error or adverse reaction; and safety issues.

Most reported incidents were classified as Level 0 or Level 1, indicating either that the referral did not meet QOC criteria or that a quality issue was not substantiated. Nine cases were classified as Level 3, representing clear and significant quality issues affecting care outcomes. Six of these cases were escalated through CCHA's Peer Review Committee (PRC) process, resulting in four CAPs. The remaining five cases were designated for tracking and trending potential emerging patterns. No Level 4 or Level 5 cases were identified.

During the year, CCHA strengthened QOCG operations through clearer Clinical Grievance and QOC procedures, streamlined Provider Relations escalation, closer alignment between QOC investigation and PRC remediation, targeted provider engagement, and implementation of a Quality of Care Reporting webform. These improvements supported more consistent intake, investigation, remediation, and monitoring.

The SFY25-26 HSAG audit identified CCHA's Behavioral Health Provider Manual QOCG reporting guidance as a best practice and identified opportunities to strengthen member communications, receipt-date documentation, case-file integrity, medical record request practices, and timely clinical triage of potential patient safety concerns. In response, CCHA updated acknowledgment language to reflect the 90-

calendar-day resolution standard; strengthened intake procedures and controls for accurate receipt-date capture; continued streamlining workflows to prevent duplicate or misclassified cases; clarified criteria for when additional clinical records are necessary; and strengthened clinical triage and escalation processes.

Ongoing QOCG improvement efforts are focused on sustaining accurate member communications and receipt-date documentation, maintaining a single complete case record, reducing avoidable delays associated with medical record requests, strengthening timely Quality Management (QM) registered nurse triage and escalation of potential safety concerns, and aligning policies and desktop procedures with operational practice and monitoring.

Managed Care Organizations (MCOs) Only

9. MCO Medicaid Loss Ratio (MLR) – Calendar Year reporting period

a. Please describe the MCO's interventions or initiatives for CY 2025 to improve performance over baseline. Summarize the results of quality program for the reporting period. Include successes, challenges and future plans. Report specific measure details in the data workbook portion of the deliverable.

10. 412 Quality Improvement Efforts- Fiscal Year reporting period

a. Report data accuracy improvement efforts based on findings from the FY 25-26 Health Services Advisory Group (HSAG) 412 Over-Read audit results. Summarize how your MCO supports practices to meet service coding accuracy. Include success, challenges, and future plans. Include specific pilot practice information in the data workbook portion (QI Efforts tab) of the deliverable if applicable.

Regional Accountable Entities (RAEs) Only

11. Regional Accountable Entity (RAEs) and Primary Care Medical Provider (PCMP) Quality Program - Calendar Year reporting period

a. RAE Quality Program - Please describe the RAE's planned interventions or initiatives to improve performance over baseline. Include information about what has already been implemented and/or completed, any early identified successes, challenges or barriers. Report the details for specific measures in the data workbook portion of the deliverable. Use data from the most recent Quality Performance Report.

Strategies Implemented and Early Successes

CCHA's RAE Quality Program is anchored in our population health infrastructure. Predictive analytics and risk stratification assign members to Tier 1 (Care Navigation), Tier 2 (Care Coordination), or Tier 3 (Care Management) based on their needs. Additionally, HCPF Quality Performance Reports, Gaps in Care reports, and member-

level data are shared with Care Coordination staff, Network Providers, and Health Neighborhood partners. This information is used to identify and target members who have not yet satisfied measure criteria. CCHA supplements this work with condition management pathways grounded in HEDIS and NCQA guidelines to support consistent, evidence-based member engagement.

For Transitions of Care, CCHA monitors daily admission, discharge, transfer (ADT) reports to flag hospital, skilled nursing, and BH admissions, discharges, and transfers, enabling early discharge planning by Care Managers and Care Coordinators. For members without an attributed PCMP, our subcontracted partner, Goodness Health, delivers telehealth-based TOC outreach for adults, supporting PCMP selection, 14-day follow-up scheduling, NEMT coordination, and medication review. In SFY25-26, Goodness Health outreached 4,929 members and completed 1,557 encounters (31.6% conversion rate).

CCHA continued BH outreach via our Ascent Health partnership for justice-involved members supporting the DOC measure, described in Section 4.For prenatal and postpartum care, CCHA uses Florence AI (Flo) to identify potentially pregnant members before claims confirmation and conducts maternity and EPSDT outreach to newly identified members. CCHA also partners with Health Neighborhood agencies, including Family Connects to provide nurse home visiting services in Boulder, Broomfield, and Jefferson counties. Services include bedside enrollment during inpatient stays, post-discharge transition-of-care outreach, and scheduling follow-up visits within 14 days. Current Quality Performance Report (QPR) results show adult Transitions of Care performance at 47.80%, compared with a 44.70% baseline.

CCHA also supports providers with workflow improvement, EHR documentation and coding, provider education, and quality improvement strategies intended to improve identification of eligible members and completion and documentation of recommended services.

Early successes have been identified in several areas. Postpartum care performance increased from 67.40% at baseline to 74.14% in the most recent QPR, exceeding the Basecamp threshold. Some PCMP performance measures are showing strong results, including Colorectal cancer screening improving from 29.84% to 34.90%, also exceeding Basecamp, supported by CCHA's population health and provider-level gap-closure efforts.

Challenges

Challenges remain for several measures and populations. Immunization performance declined during the reporting period, and some preventive measures remain below established performance thresholds despite ongoing outreach and gap-closure efforts. Barriers include difficulties with member engagement and outreach, incomplete or inaccurate contact information, and provider workflow/data capture limitations.

Planned Interventions

CCHA will continue to use our tiered risk stratification model and regional and provider-level performance data to target interventions to address identified care gaps, with particular focus on increasing engagement among historically hard-to-reach populations through multi-modal outreach. Planned strategies include expanding use of actionable patient lists and timely data, supporting providers in leveraging EHR workflows to improve preventive and chronic care, applying data analytics stratification filters (race, ethnicity, language, geography) to prioritize populations with the greatest gaps in care, and strengthening targeted outreach and care coordination for higher-risk members. CCHA will also continue to focus on BH engagement, transitions of care, and Healthy Colorado For All through collaboration with providers and community partners, monitoring performance and adjusting interventions based on emerging data, identified barriers, and provider and member feedback.

b. RAE PCMP Quality Program

- For Milestone 1:
  - Summarize the Quality Improvement (QI) activities selected by PCMPs in your region.
  - List the clinical quality measures selected for improvement within your region that will be supported by the activities selected by PCMPs.
  - Describe the QI tools and frameworks being utilized to support QI improvement efforts with PCMPs (e.g. PDSA, root cause analysis, etc.)
  - Summarize interventions that have been implemented.
- For Milestone 2:
  - Summarize ongoing activities and efforts your PCMPs are continuing to work on.
  - Describe any early to mid-year successes that have been identified.
  - Summarize challenges and barriers encountered by practices within your region.

Milestone 1 Activities

CCHA's Practice Success Facilitators supported practice-level efforts by providing data interpretation assistance, workflow and coding guidance, and targeted provider education to help PCMPs identify and act on care gaps.

Of CCHA’s 232 PCMPs, 213 (91.8%) chose to participate and identified at least one QI activity in support of their selected clinical quality measures during Milestone 1, exceeding the Summit target. Participating PCMPs established annual and mid-year goals for two QI activities designed to improve performance on selected clinical quality measures. The most frequently selected QI activity categories were workflow

optimization and monitoring, followed by other practice-specific interventions, staff education and training, and patient engagement. CCHA helped practices identify and tailor QI activities according to practice-specific quality improvement opportunities. Practices identified intermediate goals to support progress toward their annual goals.

Measure Selection

PCMPs selected QI activities supporting a range of clinical quality measures. The measures most frequently selected for improvement were:

- Controlling High Blood Pressure
- Screening for Depression and Follow-Up
- Glycemic Assessment for Patients with Diabetes
- Colorectal Cancer Screening
- Child and Adolescent Well-Care Visit
- Well-Child Visits in the First 30 Months of Life
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Developmental Screening in the First Three Years of Life
- Chlamydia Screening in Women
- Immunizations for Adolescents

The greatest concentration of QI activities focused on Controlling High Blood Pressure, Screening for Depression and Follow-Up, and Glycemic Assessment for Patients with Diabetes. Additional activities addressed preventive screening, pediatric and adolescent preventive care, and immunizations.

QI Tools and Frameworks

PCMPs utilize multiple QI tools and approaches based on the needs of the practice and selected measure. These include Plan-Do-Study-Act (PDSA) cycles, root cause analysis, baseline assessment, workflow review and optimization, performance monitoring, patient registries and care gap lists, and targeted patient outreach.

Practices are also using staff and provider education, EHR workflow changes, structured documentation, and coding improvements to address identified gaps. For example, practices have used PDSA cycles to test changes intended to improve capture of blood pressure results, root cause analyses to identify barriers affecting performance, and patient registries to identify members overdue for preventive services. These approaches allow PCMPs to identify opportunities, test interventions, monitor progress, and adjust workflows as needed.

Interventions

PCMPs initiated interventions including development and standardization of clinical workflows, establishment of patient registries and care gap lists, implementation of targeted patient outreach, improvements in clinical documentation and coding

processes, performance data monitoring, provision of staff and provider education, and workflow change testing and validation.

Interventions have been designed around the specific barriers identified by each practice. Examples include developing standardized processes for obtaining and documenting blood pressure readings; improving the use of CPT II codes and structured EHR fields; identifying patients overdue for mammography, colorectal cancer screening, or well-child visits and conducting targeted outreach; and testing workflow changes through PDSA cycles. Practices established mid-year milestones to evaluate implementation and progress toward their annual goals.

Milestone 2 Activities

During Milestone 2, PCMPs continued implementing and monitoring the QI activities established during Milestone 1. Ongoing work included refining clinical workflows, monitoring performance and care gaps, maintaining patient registries, conducting targeted patient outreach, improving EHR documentation and coding, providing staff and provider education, and continuing PDSA and root cause analysis activities where applicable. PCMPs continued working toward their annual goals while using the mid-year goals established during Milestone 1 as interim measures of progress. Activities remained focused primarily on chronic disease management, behavioral health screening and follow-up, preventive cancer screening, pediatric preventive care, and immunizations.

Successes

PCMPs demonstrated strong progress toward their annual QI goals at the mid-year reporting point. Of the 213 PCMPs eligible for Milestone 2, 207 PCMPs (97.18%) achieved the mid-year goal for at least one QI activity, exceeding the Summit target. Further, 205 PCMPs (96.24%) met the mid-year goal for both QI activities.

These results demonstrate broad implementation of the QI activities established during Milestone 1 and indicate that most participating PCMPs remained on track toward their annual goals. Early successes included implementing new or revised workflows, developing patient registries and outreach processes, completing PDSA cycles and root cause analyses, and improving documentation and coding processes intended to improve the accuracy and completeness of clinical quality reporting.

Challenges

PCMPs encountered several operational challenges during the reporting period. Staff turnover and changes in practice leadership affected continuity at some practices and required the identification of new Administrative Champions. Practice closures and contract terminations also affected participation during the reporting period.

The Milestone 1 and Milestone 2 documentation also reflects practice-level improvement efforts addressing challenges related to workflow consistency, identifying eligible patients and care gaps, EHR documentation and data capture,

coding processes, and patient outreach. Practices used QI approaches such as root cause analysis, workflow optimization, PDSA testing, registries, monitoring, and staff education to address these identified opportunities. Despite these challenges, the high percentage of PCMPs meeting their mid-year QI goals indicates that practices generally continued to make progress toward their annual improvement goals.

12. Behavioral Health Incentive Program (BHIP) - Calendar Year reporting period

a. Please describe the RAE's planned interventions to improve performance over baseline for CY 2026. Include current success, challenges and future plans. Report details for specific measures in the data workbook portion of the deliverable. Use data from the most recent Quality Performance Report.

Beginning with CY2026, the State's measurement of BHIP indicators transitioned from a fiscal year to a calendar year period to align with HEDIS reporting and is measured for CCHA's consolidated Region 3. The program includes Initiation and Engagement of Substance Use Disorder Treatment (IET4BT), Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7), Follow-Up After Emergency Department Visit for Substance Use within 7 Days (FUA7), Follow-Up After Emergency Department Visit for Mental Illness within 7 Days (FUM7), and the two-part depression screening and follow-up measure (CDF) for adults and children.

CCHA uses dashboards to monitor BHIP measures, identify emerging trends and opportunities, validate results, and guide provider and member interventions. This approach builds on strong performance in the prior incentive period, when final State calculations showed CCHA earned incentives on nine of ten Regions 6 and 7 measure opportunities, with Region 7 FUA as the only measure not met.

Current CY2026 performance is preliminary. The most recent State calculated data available, through CY2026 Q1, are rolling 12-month rates that include three quarters of CY2025 and therefore do not yet represent final CY2026 performance. Based on these results, IET4BT exceeds the Summit threshold; FUA7 and FUM7 exceed Treeline; and FUH7 exceeds Basecamp. For CDF, the adult rate exceeds Treeline while the rate for children ages 12 to 17 exceeds Basecamp.

CCHA employs coordinated provider, member, and care management interventions aligned with the factors influencing each measure. Provider-focused strategies include the Behavioral Health Quality Incentive Program (BHQIP), Behavioral Health Facility Incentive Program (BHFIP), Comprehensive Safety Net Provider Pay for Quality Program (CSNP P4Q), performance feedback, and quality education. These programs reinforce accountability for behavioral health engagement and timely follow-up and provide participating providers with actionable performance information.

For CDF, CCHA promotes standardized depression screening and documented follow-up through our ACC Quality Program, provider education, and KPI best practice guidance. Strategies emphasize integration of screening into routine preventive and

clinical workflows, standardized screening tools, appropriate follow-up after a positive screen, and accurate documentation. Healthy Rewards incentives for annual well-care visits provide an additional opportunity to encourage completion of preventive services that include depression screening.

Care Coordination supports IET4BT and follow-up measures through BH transitions of care, including post-discharge outreach, follow-up scheduling, identification of barriers, and connection to community resources. Healthy Rewards provides member incentives for eligible follow-up activities. To further improve timely follow-up after ED visits, CCHA implemented automated text message outreach to members following discharge, complementing existing care coordination activities for members receiving care management services. Together, these multidisciplinary interventions support improved access to follow-up care, address social and logistical barriers, and promote sustained improvement in BH performance measures.

Timely behavioral health follow-up remains dependent on coordination across facilities and outpatient providers, successful member contact, and member attendance. Beginning in CY2027, the new PIP interventions will provide additional focused quality improvement activity related to behavioral health transitions of care and seven-day follow-up after ED visits for substance use (FUA7). The Transitions of Care nonclinical PIP will focus on timely discharge notifications from inpatient hospitals, expected to support effective transition planning, enable care management teams to initiate outreach, coordinate follow-up services, address barriers, and connect members with outpatient behavioral health and community-based supports.

BHIP performance monitoring is constrained by data availability and reconciliation limitations. The lag and rolling nature of State-reported data limits assessment of interventions implemented during the current measurement year. In addition, State calculations rely on accepted encounter data and may differ from CCHA's internal claims-based projections while encounter submission and reconciliation processes continue to be refined. Available detail files also do not consistently include the necessary event date fields needed for full reconciliation and validation of results against CCHA records.

2026 Quality Report Deliverable Exemptions

The following sections are exempt for the 2026 Annual Quality Report deliverable submission, and will be included starting in 2027 submission:

- Healthy Colorado for All
- Adult and Child Core Measure Set