COLORADO
Department of Health Care Policy & Financing

Annual Quality Report

Narrative Report

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RAE/MCO Region: Region 4
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Purpose: Colorado Access is responsible for a variety of quality improvement initiatives as part of the Accountable Care Collaborative (ACC) program. These initiatives are outlined in the Colorado Access quality improvement plan that was submitted in July 2025. This report outlines the efforts to implement this plan over the previous fiscal year (FY) and/or calendar year (CY), the results of those efforts, and changes to Colorado Access' approach.

1. Summary of your overall quality approach

Colorado Access approaches quality improvement as a continuous, data-driven, and cross-functional discipline that is embedded across the organization rather than confined to a single department. The overarching aim for FY 2026 (July 1, 2025, to June 30, 2026) was to strengthen the infrastructure, governance, and analytic capabilities that allow us to identify improvement opportunities quickly, prioritize the interventions with the greatest potential impact, and evaluate whether those interventions produce measurable gains for members. Throughout the reporting period, Colorado Access focused on maturing the systems that connect performance data to action, aligning historically separate bodies of work under a common governance structure, and reinforcing the feedback loops with internal and external committees. The result is a quality program that is more coordinated, transparent, and accountable for outcomes, in alignment with contractual requirements.

Quality Goals and Priorities for FY 2026

The quality priorities for FY 2026 are centered on three interconnected goals. First, Colorado Access sought to advance data-driven decision-making for performance metrics so that improvement opportunities could be surfaced and acted upon in real-time. Second, the governance of quality initiatives was strengthened and prioritized to ensure that interventions were intentionally selected, formally overseen, and rigorously evaluated. Third, Colorado Access committed to reducing organizational silos by deepening collaboration across the departments that collectively influence member outcomes. These goals were selected because they address the foundational capabilities of data, governance, and cross-functional alignment that determine whether individual interventions can be sustained and scaled into lasting performance improvement.

Use of Data to Identify Opportunities and Monitor Progress

Data is the foundation of the approach to quality at Colorado Access. During FY 2026, Innovaccer served as the primary metric performance and analytics platform for the organization, used for real-time rate reporting and to direct targeted interventions toward the members, measures, and practices with the greatest opportunity for improvement. Innovaccer allows teams to monitor performance against benchmarks throughout the year rather than waiting for retrospective, end-of-year results, which in turn shortens the time between identifying a gap and deploying a response. Building on this foundation, a key priority has been to advance analytics maturity so that data can be sliced, diced, and displayed in ways that clearly highlight where improvement opportunities exist, whether by measure, member population, geography, or provider. To keep multiple programs aligned to a single source of truth, teams also maintain a measure crosswalk that reconciles metrics across programs and highlights gaps in vendor reporting, ensuring consistency in how rates are defined and tracked across the organization.

Governance Tools

A central accomplishment of the reporting period was the continued implementation and maturation of the Outcomes and Measurement Committee (OMC), which provides an increased governance structure over metrics and interventions. The OMC creates a centralized process for prioritizing interventions, providing oversight, and evaluating results, so that decisions about where to invest quality resources are made deliberately and with organizational visibility. Complementing this governance structure, Colorado Access developed a formal intervention evaluation tool that enables the structured and consistent evaluation of interventions. Together with standardized processes for intervention development, monitoring, and reporting, these tools have improved visibility into the progress, barriers, and outcomes associated with each initiative, and they provide the documentation needed to determine which interventions should be continued, refined, spread, or discontinued.

Incorporating Internal and External Committees to Report out and Elicit Feedback

Colorado Access intentionally uses the internal and external committees to report on quality efforts and to elicit meaningful feedback that shapes work and prioritization. The Program Improvement Advisory Committee (PIAC) provides valuable external stakeholder feedback on intervention design and implementation, helping ensure that improvement efforts reflect community and member perspectives. Consulting efforts related to the Healthy Colorado For All (HCFA) work ensures interventions are aligned and positioned for high impact by removing obstacles to health care access. Internally, the Behavioral Health (BH) and Physical Health (PH) subcommittees serve as primary forums for monitoring performance, evaluating intervention effectiveness, and recommending strategies that improve outcomes across programs. The Prenatal and Postpartum Care (PPC) and Transitions of Care (TOC) workgroups bring together

cross-functional partners to identify interventions, gaps and opportunities and to develop targeted improvement strategies. These committees create structured feedback loops through which results are shared, analyzed, and refined.

Key Accomplishments

The FY 2026 quality approach produced several notable accomplishments:

- Strengthened governance of quality improvement initiatives through the implementation and maturation of the OMC, creating a centralized process for intervention prioritization, oversight, and evaluation.
- Reduced organizational silos by increasing collaboration across quality, population health, care coordination, practice support, and analytics, resulting in more coordinated quality improvement efforts and shared accountability for outcomes.
- Aligned quality performance measures, Shared Savings, Healthy Colorado For All, and other quality initiatives under a common governance structure to improve prioritization, reduce duplicative work, and maximize organizational impact.
- Established standardized processes and tools for intervention development, monitoring, and reporting, improving visibility into progress, barriers, and outcomes.
- Advanced targeted interventions in key focus areas, including prenatal and postpartum care, transitions of care, diabetes, and behavioral health through cross-functional workgroups and shared accountability structures.

2. Updates to your plan

During FY 2026, Colorado Access made a series of modifications to its Quality Improvement Plan that reflect the natural evolution of ACC Phase III and lessons learned from the first year of operating under the maturing governance structure. The changes described below were made to sharpen the focus on the highest-impact measures, to strengthen the accuracy and completeness of the data underpinning performance rates, and to formalize the Performance Improvement Projects (PIPs) required under ACC Phase III. Collectively, these updates position Colorado Access to improve performance across priority measures while maintaining alignment among quality, population health, care coordination, and provider engagement activities.

Selected Clinical and Nonclinical ACC Phase III Performance Improvement Projects

A significant modification to the plan during the reporting period was the selection and formal approval of the ACC Phase III PIPs. The FY 2026 PIP cycle focused on two statewide topics selected by the Department: one clinical and one non-clinical. For the clinical PIP, all health plans were required to address the “Follow-Up After Emergency Department Visit for Substance Use (FUA) – 7-Day” measure, with a focus on improving timely follow-up care after substance use-related emergency department visits. For the nonclinical PIP, Colorado Access selected the performance indicator "Outreached Region 4 Members Unattributed to a Comprehensive

Safety Net Provider (CSNP) with Behavioral Health Inpatient Admissions Who Were Either Tier 3 or Age 20 and Under" to increase outreach and care coordination for members at elevated risk during transitions of care. The nonclinical topic was selected based on analysis of internal performance data and its clear connection to member outcomes following a behavioral health discharge, and it reflects an intentional focus on plan-driven activity (outreach attempts). Subsequently, a business-intelligence (BI) dashboard was developed to assess pre-baseline, baseline, and current-state performance.

Quality Goals and Priorities for FY 2027

Looking ahead to FY 2027 (July 1, 2026, to June 30, 2027), Colorado Access will continue to prioritize data completeness and accuracy, including through the integration of Contexture (health information exchange) supplemental data feeds, to further identify opportunities and close data gaps. Incorporating Contexture supplemental data into performance measurement processes will improve measure accuracy, close gaps in data, and better identify where interventions yield the highest impact. Colorado Access will also continue to pursue Shared Savings opportunities as part of the broader strategy for cost containment and improved clinical care. Clinical and operational priorities for FY 2027 include:

- Expanding and enhancing interventions focused on postpartum care, diabetes poor control, hypertension, and transitions of care to improve outcomes and drive performance across quality measures.
- Leveraging enhanced data and population health analytics to better understand the members represented within each measure, identify the drivers of performance, and prioritize interventions that close disparity gaps and improve health outcomes.
- Continuing to align quality, population health, care coordination, and provider engagement activities to support metric achievement across priority measures.
- Advancing intervention evaluation capabilities to better assess effectiveness, inform decision-making, and support continuous improvement.

Tools Planned for FY 2027

To support these priorities, Colorado Access is launching a Glycemic Status Assessment for Patients with Diabetes (GSD) workgroup to identify opportunities and develop targeted interventions aimed at improving performance on this measure. Colorado Access will use the evaluation tool to monitor intervention implementation, assess effectiveness, and inform ongoing refinements to improvement strategies. Colorado Access intends to:

- Implement enhanced intervention tracking and evaluation tools to better measure impact, identify opportunities, and support data-driven decision-making.
- Develop intervention tracking tools to monitor leading indicators and support timely evaluation, refinement, and scaling of improvement strategies.

Internal and External Committees Supporting FY 2027 Efforts

Both internal and external committee structures will continue to serve as the backbone for reporting quality efforts and eliciting feedback in FY 2027. Planned committee engagement will include deeper PIAC integration to strengthen external stakeholder input on intervention design and implementation; participation in National Committee for Quality Assurance (NCQA)-aligned committees, including the Quality Management Committee (QMC), the OMC, and associated subcommittees; and engagement with the Health Equity Committee and HCFA consulting efforts to ensure that interventions are aligned, highly impactful, and advance health equity. These forums will ensure that FY 2027 quality improvement activities remain transparent, collaborative, and responsive to the perspectives of members, providers, and community partners.

NCQA Accreditation Efforts

Colorado Access also advanced NCQA readiness during the reporting period by aligning committee structures, quality oversight activities, care coordination program development, member experience monitoring, and access and availability processes with NCQA expectations. This work included continued use of the Quality Management Committee and OMC governance structures, development of NCQA-aligned complex care management processes, and transition to a vendor-led access and availability survey approach. These activities support a more standardized and evidence-based quality program going into FY 2027.

3. Underutilization and Overutilization of Services

In FY 2026, Colorado Access strengthened its ability to assess the effectiveness of the mechanisms implemented to identify, monitor, and address underutilization and overutilization of services. This work took a multi-pronged approach across governance, detection, provider engagement, and cross-agency collaboration, building on goals established at the beginning of ACC Phase III and continuing into FY 2027.

Governance

To ensure coordinated, timely response to utilization trends, Colorado Access established the Utilization and Clinical Alignment Committee (UCAC) during the reporting period. The UCAC synthesizes utilization data and clinical input into actionable recommendations giving the organization a single, accountable pathway from identification of a utilization concern to deployment and monitoring of a solution. Core UCAC functions include identifying utilization trends and risks, assessing clinical appropriateness of services, developing actionable solutions, presenting recommendations for approval, deploying approved strategies, supporting implementation, and monitoring impact and success metrics.

Mechanisms for Monitoring and Addressing Overutilization

Colorado Access continued to utilize finance and utilization dashboards to identify emerging trends in FY 2026. The dashboards flag billing patterns that warrant closer review, including claims reflecting an operationally impossible volume of services billed within a single day, members with high per-capita service utilization, and providers whose billing patterns fall outside the norm relative to their peer group. These dashboards give Colorado Access an earlier and more systematic line of sight into potential overutilization than manual review alone.

The compliance team identifies audit targets by analyzing provider claims data for outlier billing patterns, monitoring the provider utilization dashboards for significant month-over-month increases in billing activity, and partnering with the data analytics team to track trends in code usage, member overlap across services, and dollars per member. In FY 2026, this team audited 60 providers: 54 were placed on Corrective Action Plans (CAPs), three received education only, one passed with no errors, and two were terminated from the network following audit findings.

The Provider Training Referral program pairs outlier providers identified through dashboards and audits with targeted coaching, including focused outreach to Peer Support Services providers. Referrals were most frequently tied to coding, documentation, and clinical behavioral health practices, with cases remaining open for an average of 81 days. The program has produced measurable results. Following coaching, one provider's utilization of the two highest-volume service codes declined substantially, with H2014 (Skills Training and Development) utilization falling 40.3% and H0038 (Self-Help/Peer Services) utilization falling 98.3% across the finalized review period, with no evidence that utilization shifted to another billing code. Another provider completed a coaching engagement addressing documentation, billing, medical necessity, and utilization management, meeting all established goals. Additionally, Colorado Access is contracted with EXL, an external vendor, to conduct broader compliance audits on utilization patterns and recoupments, extending audit capacity beyond internal staff, which has resulted in more thorough monitoring of overutilization.

Mechanisms for Monitoring Underutilization of Services

Colorado Access monitors underutilization through non-utilizer claims analysis, gaps-in-care identification, and behavioral health penetration rate tracking. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) digital engagement and direct mail interventions outreach members with no recent utilization or expected preventive and follow-up services, and behavioral health penetration rates are monitored to identify subpopulations accessing care at lower rates than the overall membership. In FY 2026, Colorado Access transitioned its access to care monitoring from an internally managed process to a vendor-led, NCQA-aligned access and availability survey with Press Ganey, which will provide a more comprehensive, benchmarked view of whether network access barriers are contributing to underutilization.

Utilization Management (UM) and Inter-Rater Reliability (IRR)

UM at Colorado Access is a powerful clinical mechanism for managing both underutilization and overutilization of services. Through prior authorization, concurrent review, and medical necessity determinations, UM works to ensure members receive medically necessary and appropriate care: authorizing services that meet criteria to protect against underutilization, while scrutinizing requests that may reflect a higher level, frequency, or duration of service than clinically indicated to protect against overutilization. A key trend driver in FY 2026 was high utilization growth in bed-based substance use disorder (SUD) levels of care with American Society of Addition Medicine (ASAM) 3.7 Withdrawal Management (WM). In response, Colorado Access strengthened its UM function as an active lever for level-of-care oversight, increasing scrutiny of authorizations in this space to identify and address potential waste and abuse alongside legitimate access needs.

Because UM decision-making is leveraged to manage risk, Colorado Access relies on its annual IRR study to confirm that authorization criteria are applied consistently across reviewers. In FY 2026, 26 behavioral health UM staff achieved an IRR score of 90% or higher on their first attempt. The remaining three staff passed on their second attempt after additional training, resulting in 100% of staff meeting IRR standards within two attempts. Six medical directors and four physical health UM staff also achieved a first-attempt score of 90% or higher. Based on these results, Colorado Access is confident that this increased UM scrutiny is being applied reliably across reviewers.

Successes, Challenges and Future Plans

Standing up UCAC gave Colorado Access a durable governance structure and the provider utilization dashboards have materially improved detection of outlier billing. FY 2026 audits resulted in corrective action for most providers reviewed, and coaching engagements produced measurable utilization normalization. Key challenges included ensuring streamlined activities across the organization and managing unprecedented behavioral health growth. Looking ahead to FY 2027, Colorado Access plans to expand its fraud, waste, and abuse (FWA) capabilities into a more sophisticated, data-driven program building on the UCAC governance model and dashboard infrastructure established in FY 2026.

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

During FY 2026, Colorado Access assessed and improved the quality and appropriateness of care provided to members with special health care needs through care coordination oversight, delegated provider monitoring, staff training, TOC program development, specialized pediatric care coordination, and community partnerships. These activities were designed to ensure

members with complex medical, behavioral health, functional, and social needs received coordinated, person-centered care and access to appropriate services and supports.

Care Coordination

Care coordination programs served as a primary mechanism for evaluating the quality and appropriateness of care for members with special health care needs. Throughout the reporting period, Colorado Access advanced readiness for an NCQA-aligned Complex Care Management program by developing member identification criteria, comprehensive assessment processes, individualized care planning standards, care coordination workflows, monitoring processes, reporting requirements, quality oversight activities, and staff training. Colorado Access also continued specialized care coordination services through its High-Needs Pediatric Team, supporting youth with complex behavioral health needs, Colorado System of Care (CO-SOC) participants, and members who opted out of CO-SOC services. Monitoring of care coordination activities identified opportunities to improve consistency in identifying high-risk members, strengthen care planning practices, and enhance coordination across providers and community-based services.

To address these opportunities, Colorado Access increased education and oversight for delegated Care Coordination Providers (CCPs), including training on risk stratification methodology, reinforcement of care planning expectations for members with the highest levels of need, and enhanced monitoring of care plan quality and volume. Additional department-wide training initiatives, including Motivational Interviewing, de-escalation techniques, and EPSDT requirements, strengthened staff capabilities related to member engagement, person-centered care planning, behavioral health support, and pediatric service coordination. Colorado Access also initiated planning and implementation activities for TOC pilot programs to improve post-discharge follow-up, continuity of care, and member engagement among high-risk populations.

Community Partnerships

Community partnerships provided an additional mechanism for assessing the appropriateness of services and identifying opportunities for improvement. Colorado Access maintained ongoing partnerships with the Colorado Cross-Disability Coalition (CCDC) and Family Voices Colorado to support members with special health care needs and their families through navigation assistance, advocacy, education, and systems improvement efforts. Through monthly consultations, staff training, listening sessions, and direct member support activities, these organizations provided valuable feedback regarding member experiences, barriers to care, and emerging needs within the disability community. Information gathered through these partnerships informed quality improvement activities and strengthened Colorado Access's understanding of how members and families experience health care services.

Successes and Challenges

Key successes during the reporting period included continued expansion of specialized care coordination services, advancement of complex care management program readiness activities, enhanced provider oversight, strengthened workforce training programs, and sustained engagement with community partners representing individuals with disabilities and families of children with special health care needs. These efforts improved Colorado Access's ability to identify service gaps, respond to member needs, and strengthen care coordination processes across the continuum of care.

Challenges and barriers identified during FY 2026 included the complexity of consistently identifying members with evolving health and social needs, variation in member acuity definitions across programs, and the need for more refined approaches to targeting care coordination resources to the members most likely to benefit from intervention. Findings from care coordination monitoring, provider oversight activities, and program development efforts highlighted opportunities to improve the precision and consistency of member identification and resource allocation.

Improvements and Future Plans

In response to these findings, Colorado Access is developing an enhanced member acuity model for implementation in FY 2027. The updated model uses the Chronic Illness and Disability Payment System plus Prescription Drugs (CDPS+Rx) version 7.2 and Johns Hopkins Adjusted Clinical Groups (ACG) methodologies to more accurately identify members with moderate and high levels of clinical complexity. The enhanced methodology is expected to improve identification of members with special health care needs, better align care coordination resources to member needs, support more consistent decision-making across programs and partners, and reduce reliance on state-developed condition flags that may not fully reflect current health status. Future priorities include implementation of the enhanced acuity model, continued development of the complex care coordination program, expansion of TOC initiatives, implementation of a hybrid care coordination model in partnership with providers, and ongoing collaboration with community partners to ensure members with special health care needs receive high-quality, appropriate, and coordinated care.

5. External Quality Review Organization (EQRO) Compliance

Colorado Access participates in an annual external independent compliance review audit to confirm compliance with federal health care regulations outlined in 42 CFR 438 and contractual requirements. This review is conducted by Health Services Advisory Group (HSAG), and HSAG works collaboratively with the Department for which it performs external compliance review services to help improve the quality of care provided to Health First Colorado recipients.

FY 2026 Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of met, partially met, not met, or not applicable. HSAG assigned required actions to any requirement receiving a score of partially met or not met. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

The table below summarizes audit scores for each standard included in the audit.

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Disenrollment: Requirements and Limitations	5	5	4	1	0	0	80%
IV. Availability and Assurances of Adequate Capacity and Services	15	15	13	2	0	0	87%
VII. Coverage and Authorization of Services	34	34	27	7	0	0	79%
X. Grievance and Appeal Systems	35	35	28	7	0	0	80%
Totals	**89**	**89**	**72**	**17**	**0**	**0**	**80%**

Findings by Standard:

Standard I. Disenrollment: Requirements and Limitations

- No clearly documented and articulated operational process for Colorado Access-initiated disenrollment

Standard IV. Availability and Assurances of Adequate Capacity and Services

- No ongoing monitoring process for provider hours of operation
- No ongoing monitoring to ensure continued physical access and accommodation for members with disabilities

Standard VII. Coverage and Authorization of Services

- Inconsistent provider outreach prior to denials for missing information
- Notice of Adverse Benefit Determination (NABD) frequently lacked plain-language explanations and clearly defined criteria
- Staff could not consistently articulate emergency services prior authorization rules

Standard X. Grievance and Appeal Systems

- Misclassification of grievances, claims, and appeals
- Inconsistent understanding of expedited appeal criteria and program routing
- Member letters lacking clarity, required Spanish taglines or clearly stated resolutions

Actions Taken to Address Findings and Future Plans

As a result of findings identified during the compliance review audit, HSAG issued 17 CAPs to Colorado Access. The responsible operational areas have begun implementing targeted interventions to address the deficiencies identified and achieve compliance with CAP requirements. This work will continue throughout the summer, with all corrective actions and supporting evidence of completion due to HSAG by September 8, 2026.

The review also demonstrated the ongoing commitment Colorado Access has monitoring compliance with federal and contractual requirements through established policies, operational processes, staff interviews, and document reviews. Key challenges identified during the audit included opportunities to strengthen process standardization, staff understanding of regulatory requirements, provider outreach practices, and the consistency and clarity of member communications. In response, operational teams are updating policies and procedures, enhancing staff training and education, implementing additional oversight and monitoring activities, and revising member-facing materials to improve clarity and regulatory compliance. These corrective actions are intended not only to resolve the specific audit findings but also to strengthen long-term compliance monitoring and support continuous quality improvement efforts throughout the organization.

6. Member Experience

The member experience department at Colorado Access collects and analyzes member feedback to drive improvements across the organization. Member experience is assessed through multiple qualitative and quantitative sources, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Experience of Care and Health Outcomes (ECHO) surveys, customer service and care coordination net promoter scores (NPS) surveys, program evaluations, biannual member insights surveys, grievance data, member advisory councils, external advisory committees, focus groups, community engagement activities, and usability testing of member communications.

Physical Health CAHPS Survey

In 2025, CAHPS response rates continued to decline statewide, though Colorado Access regions remained above the state average. Due to limited statistical significance for many measures, results were used primarily for directional guidance. Adult survey results showed stronger performance in Region 3 than Region 5, while child survey performance was similar across

regions. Across surveys, the most consistent opportunities for improvement were Getting Care Quickly, How Well Doctors Communicate, and Customer Service.

Behavioral Health ECHO Survey

Colorado Access launched administration of the ECHO survey during the reporting period and contracted with Press Ganey for annual deployment. In 2025, Colorado Access exceeded benchmark performance on Getting Treatment Quickly and Informed about Treatment Options but scored below benchmark on four measures: Rating of Counseling and Treatment, How Well Clinicians Communicate, Perceived Improvement, and Getting Treatment and Information from the Plan. Members reported complex behavioral health needs, high service utilization, and challenges accessing customer service. Experience disparities were identified across age, race, and ethnicity.

Biannual Member Insights Survey

The member experience team partners with customer service to collect feedback from members about twice a year through calls to the call center on rotating topics of interest to Colorado Access. The fall 2025 survey (n=525) examined how members access information. The top reasons for contacting customer service were finding a provider, checking eligibility, changing a PCP, and billing questions. Most respondents (67%) contacted Colorado Access directly without seeking information elsewhere. The spring 2026 survey (n=612) focused on the PEAK platform. Fifty-eight percent of respondents reported using PEAK. Among those providing feedback, two-thirds reported a positive experience, and one-third reported a negative experience. The most common recommendation was improved instructions for using the platform.

Sharing Survey Results

Survey findings are shared across Colorado Access departments and committees to inform process improvements and strategic initiatives, including customer service enhancements, care access, network development, population health planning, and health equity efforts. Colorado Access is also expanding the external sharing of results through member and provider communications, advisory councils, and its website.

Interventions Based on Findings

Based on CAHPS, ECHO, and other member experience data, Colorado Access identified several improvement opportunities to improve and strengthen member experience:

- Your Voice Counts member voice program: In order to collect member voice at scale, during the reporting period Colorado Access launched Your Voice Counts, which is a voluntary, opt-in database of Colorado Access members and caregivers who agree to be available to Colorado Access to share their feedback and experiences through story sharing, surveys, focus groups, usability testing, and advisory committees. It supports a

proactive and member-centered approach by making it easier to gather feedback over time, test ideas, and include member voice in decision-making across departments.

- External Feedback Loop implementation: Colorado Access has developed formal processes and procedures for centrally managing all external feedback, including member feedback, and assigning it to appropriate individuals and teams for action. A centralized database called the Consolidated List of External Feedback was created to track where it is assigned and what is done with the feedback to create greater accountability across the organization and to be able to identify global feedback trends for Colorado Access leadership. As of the end of this reporting period, 40 unique feedback items are being tracked.
- Colorado Access will continue strengthening the provider network by shifting from an "any willing provider" approach to strategic network development that prioritizes providers prepared to deliver whole-person care. This work will support targeted investment in high-performing providers, maintain access, stabilize safety-net providers, and use value-based strategies, provider feedback, and member experience data to refine best practices.
- Colorado Access launched an Attribution Strategy pilot to improve access and continuity by connecting Regional Accountable Entity (RAE)-assigned and unattributed members to care coordination practices through warm handoffs and appointment support. The pilot will be monitored in 2026 for impacts on access, utilization, continuity, and member experience.

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

The FY 2026 PIP cycle focused on two statewide topics selected by the Department: one clinical and one non-clinical. For the clinical PIP, all health plans were required to address the Follow-Up After Emergency Department Visit for Substance Use (FUA) – 7-Day measure, with a focus on improving timely follow-up care after substance use-related emergency department visits. For the non-clinical PIP, all health plans were required to address behavioral health transitions of care. Colorado Access selected the performance indicator Outreached Region 4 Members Unattributed to a CSNP with Behavioral Health Inpatient Admissions Who Were Either Tier 3 or Age 20 and Under, to increase outreach and care coordination for members at elevated risk during transitions of care.

FUA Successes, Challenges, Lessons Learned, and Future Plans

Colorado Access conducted an internal analysis to identify emergency departments (EDs) with lower FUA performance and engaged two EDs to better understand workflows, barriers to follow-up care, and opportunities for improvement. Through these discussions, Colorado Access identified challenges affecting timely follow-up and explored strategies to strengthen care transitions. One ED demonstrated strong interest in collaboration, and Colorado Access

facilitated introductions to a newly contracted telehealth provider specializing in SUD treatment to expand referral options. The ED also established an Engagement Specialist role, focused on resource navigation and member support. These developments will create opportunities for stronger care coordination, warm handoffs, and improved connections to outpatient treatment following an ED visit.

Access to timely, actionable data remains a challenge. While monthly RAE-level performance data are available through Innovaccer, provider- and facility-level data are needed to identify variation in performance and support targeted improvement efforts. At present, individualized data are not consistently available, limiting the ability to prioritize and evaluate interventions. This work reinforced the importance of strong partnerships with emergency departments and community treatment providers. It also highlighted that barriers to follow-up vary across organizations and require tailored interventions. Finally, the project demonstrated that meaningful improvement efforts depend on access to detailed, actionable data.

Colorado Access will continue enhancing its data infrastructure to support provider- and facility-level analysis and more targeted interventions. Colorado Access will also continue building relationships with emergency departments and outpatient SUD providers to strengthen referral pathways and care transitions. Although overall performance has shown gradual improvement, FUA remains a challenging measure and will require continued innovation and collaboration.

Behavioral Health Transitions of Care Successes, Challenges, Lessons Learned, and Future Plans

Colorado Access developed a targeted outreach process to support Region 4 members experiencing a behavioral health inpatient admission who were not attributed to a CSNP. A key success during this PIP cycle was the implementation of Personify, a healthcare technology platform that supports member engagement through interactive voice response (IVR) and text messaging. Beginning March 27, 2026, outreach was expanded to include automated IVR calls and text messages within three days of discharge. This enhancement reduced reliance on manual outreach, decreased the risk of missed outreach opportunities, and provided additional channels to engage members during a critical transition period.

Outreach efforts continue to be impacted by outdated contact information, disconnected phone numbers, and limited member engagement following discharge. In addition, this is a Colorado Access-developed metric, requiring all reporting, monitoring, and analysis processes to be built and maintained internally. Developing and validating the necessary data infrastructure requires considerable time and resources. While IVR and text messaging outreach began in March 2026, these activities have not yet been incorporated into the current performance calculations and are therefore not fully reflected in reported rates. This project

reinforced the importance of timely outreach following a behavioral health inpatient admission. Early engagement can help connect members to needed services and reduce gaps in care. The project also highlighted the importance of accurate member contact information and reliable data sources to support both outreach activities and performance monitoring.

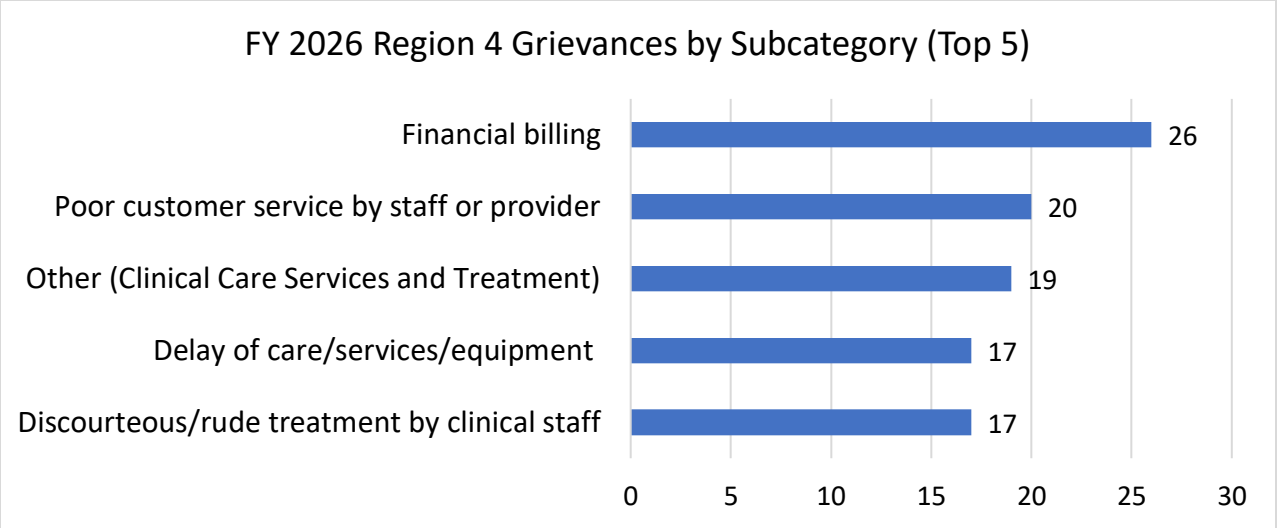
Colorado Access will continue refining outreach processes for high-risk members following behavioral health inpatient admissions. Future efforts will focus on enhancing internal dashboards and reporting capabilities to better identify barriers to timely outreach and support root cause analysis. By strengthening outreach processes, improving performance monitoring, and incorporating new engagement methods into reporting, Colorado Access aims to improve behavioral health transitions of care and ensure members receive timely support following discharge.

8. Quality of Care Grievances (QOCGs)

One way that Colorado Access monitors member experience is through the QOCG process. Members have the right to submit grievances to Colorado Access regarding any aspect of the operations, activities, or behavior of the health plan or the Colorado Access contracted provider network. Customer service staff monitor member grievance data to identify sources of dissatisfaction with care or service delivery and patterns by aggregating this data quarterly. The quality of care concern (QOCC) process investigates concerns related to the quality, safety, and appropriateness of care provided to members and uses findings to support quality improvement activities.

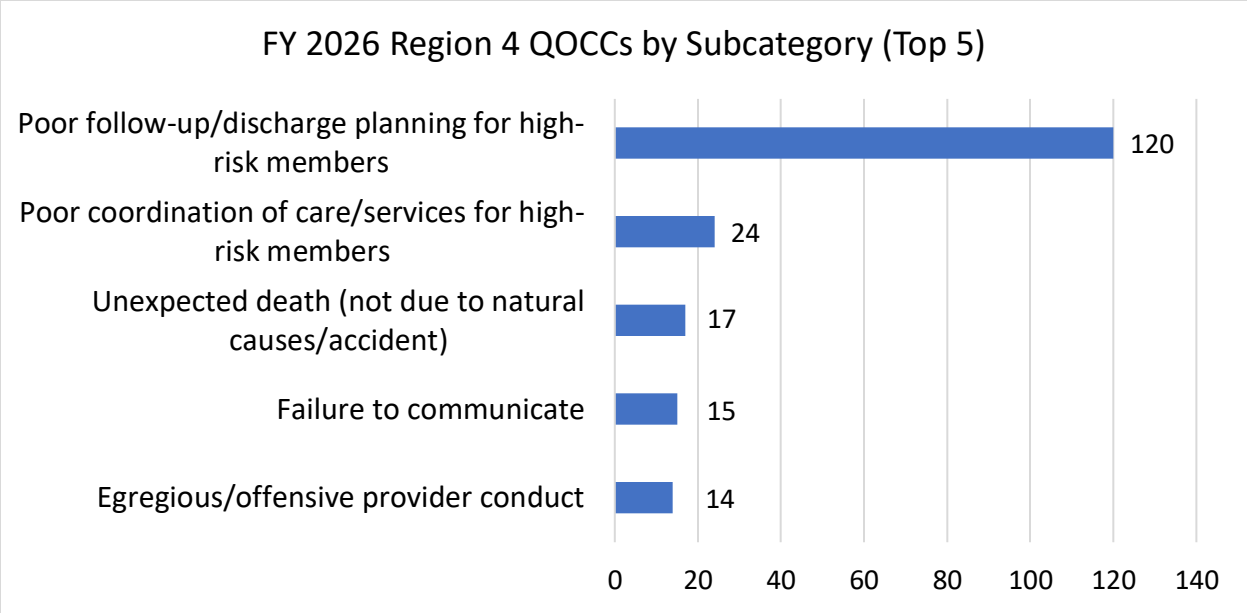
Grievance Results and Trends

In FY 2026, a total of 223 grievances were filed by Region 4 members. Clinical Care Services and Treatment accounted for 74 grievances (33.2%), while Customer Service or Professional Conduct also accounted for 74 grievances (33.2%). The remaining grievances were categorized as Access and Availability, Patient Safety or Health Outcomes, and Other. All grievances were resolved in a manner that members considered satisfactory, and all grievances were processed within required timeframes, resulting in 100% compliance with contractual grievance processing timelines. Colorado Access utilized a grievance quality auditing program to monitor the timeliness of grievance resolutions, the content of letters sent to members, the readability of letters, and case documentation in the grievance tracking tool. Five cases per grievance coordinator were reviewed for quality monthly. Upon review, the supervisor provided timely feedback to the grievance coordinator based on the findings. In FY 2026, the average score of audited grievances was 99%, surpassing the 95% target.



QOCC Results and Trends

In FY 2026, Colorado Access received 278 QOCCs for the Region 4. Clinical Care Services and Treatment accounted for 176 QOCCs (63.3%), while Patient Safety or Health Outcomes accounted for 70 QOCCs (25.2%). This represents a 67.5% increase from the 166 QOCCs received during FY 2025 (July 1, 2024, to June 30, 2025). To support accurate reporting and escalation of quality concerns, Colorado Access provided targeted QOCC education to internal staff and largest CSNP partners. Substantiated cases increased from 23% in FY 2025 to 40% in FY 2026, reflecting improved identification and reporting of concerns warranting formal quality review across Colorado Access and the provider network. Investigation findings and trend analyses informed referrals to the Colorado Access Individualized Provider Training Program, corrective actions, and broader quality improvement activities. To further strengthen oversight and reporting processes, Colorado Access developed and implemented a Jira-based workflow to streamline QOCC intake, tracking, and reporting activities and transitioned to a secure online submission process effective July 1, 2026. The average QOCC case closure time improved from 40 days in FY 2025 to 38 days in FY 2026.



Opportunities for Improvement

Colorado Access will sustain utilization of the quality monitoring program to ensure grievance processes are followed and grievances are closed out in a timely manner. Moving into FY 2027, grievance coordinators will receive detailed insights from quality audits and automated reviews, allowing the Genesys system to analyze conversations and identify improvement areas, leading to increased member satisfaction. Colorado Access will continue to maintain compliance with contractual and reporting requirements while leveraging trend analysis, investigation results, and quality audit results to support ongoing quality improvement efforts. Key priorities include monitoring timeliness and case outcomes, identifying emerging trends and referral patterns, and using findings to inform targeted interventions, corrective actions, and opportunities for provider and staff education. Audit findings will be used to implement targeted raining, standardized guidance, and clear escalation pathways, to support consistent identification and routing of cases requiring medical director involvement. Colorado Access will continue refining policies, procedures, and cross-functional coordination to strengthen oversight, improve operational efficiency, and to deliver a high-quality experience for grievance and QOCC submitters.

11. RAE and Primary Care Medical Provider (PCMP) Quality Program

The Region 4 Quality Program supports PCMPs through practice facilitation, data-driven quality improvement, workflow redesign, coding and documentation support, and measure-specific coaching. Practice facilitators partner with practices to identify priority measures, set goals, analyze QPR data, review member-level performance details, map workflows, optimize EHR processes, and implement targeted improvement strategies. Ongoing support includes coding education, resource sharing, and regular performance reviews to guide action planning. Many

practices selected workflow-focused quality improvement projects in response to data lag, attribution challenges, and limitations in real-time performance reporting. This approach enabled practices to make meaningful operational improvements while strengthening systems for screening, outreach, follow-up, documentation, coding, and chronic disease management.

Milestone 1: Summary of Quality Improvement (QI) Activities Selected by PCMPs

Across Region 4, PCMPs selected projects focused on improving clinical workflows, strengthening documentation and coding accuracy, closing care gaps, and building reliable processes for screening, outreach, follow-up, and chronic condition management. Practice facilitators supported this work through coaching, data review, workflow optimization, staff training, and measure-specific technical assistance.

Clinical Quality Measure	Practices
Breast cancer screening	3
Cervical cancer screening	20
Colorectal cancer screening	41
Controlling high blood pressure	112
Glycemic status/diabetes-related care	54
Chlamydia screening	4
Screening for depression and follow-up	138
Child and adolescent well-care visits	33
Childhood immunizations status	16
Developmental screening in first 3 years	5
Immunizations for adolescents	5
Well-child visits in first 30 months	68
Risk-enhanced care coordination for chronic conditions	6

Tools and Interventions

Most practices are using an A3 or Plan, Do, Study, Act (PDSA) framework to guide improvement work. Some practices also used root cause analysis methods, including 5 Whys and/or fishbone diagrams, to better understand contributing factors and shape their PDSA cycles or A3s. These tools support barrier identification, current-state workflow mapping, solution testing, and sustainable process development.

- Depression Screening and Follow-Up: Practices are standardizing screening and risk assessment tools, improving follow-up workflows and documentation, implementing electronic health record (EHR) alerts, and automating coding, where available.
- Controlling High Blood Pressure: Practices are standardizing blood pressure measurement and recheck processes, reinforcing documentation and coding standards, training staff, and leveraging EHR workflows to improve coding whenever feasible.

- Glycemic Status and Diabetes Care: Practices are identifying and engaging patients with diabetes, expanding outreach efforts, increasing timely hemoglobin testing and documentation, implementing EHR reminders, supporting continuous glucose monitor (CGM) ordering workflows, and promoting consistent coding.
- Preventive and Pediatric Measures: Practices are improving workflows for cancer screenings, well-child visits, developmental screenings, and immunizations, including enhancements aligned with Combo 2 and Combo 10 measure requirements.

One practice conducted Gemba walks across three clinic locations, including workflow mapping with scheduling, front desk, clinical, provider, behavioral health, billing, and coding teams, a comparison of workflow variation across sites, and redesign of depression screening and Chlamydia testing workflows. Changes included electronic screening tools, standardized screening criteria, follow-up processes for emergent and non-emergent behavioral health needs, billing and documentation standardization, universal screening discussions, staff scripting, and patient/parent education.

Milestone 2: Ongoing Activities

During Milestone 2, PCMPs continue to implement and refine the QI plans started in Milestone 1. Efforts remain focused on workflow standardization, staff education, coding optimization, preventive screening workflows, chronic disease management, care coordination expansion, and use of data to guide improvement. Practices are conducting chart reviews, monitoring dashboards, outreaching patients with care gaps, implementing PDSA cycles, and strengthening workflows related to depression screening, blood pressure control, diabetes management, cancer screenings, well-child visits, immunizations, and risk-enhanced care coordination.

Early to Mid-Year Successes

Practices reported meaningful progress across several areas. Many teams completed workflow mapping, root cause analyses, and process redesign activities; updated clinical and billing workflows; created standardized screening and follow-up processes; and developed outreach workflows for overdue patients and missed appointments. Several organizations also reported stronger coordination among clinical, billing, care coordination, and administrative teams. Providers expressed appreciation for increased alignment of quality measures across programs and recognized the value of meaningful financial incentives. Practices noted that consistent expectations and incentive structures help prioritize improvement work, sustain engagement, and support investment in workflow redesign, staff training, and long-term improvement.

Challenges and Barriers

Despite strong engagement, practices continue to face barriers that affect implementation and measurement. The most significant challenges are related to timely and accurate data, attribution and reporting issues, coding and billing complexity, EHR limitations, workforce

capacity, and administrative burden. Practices also noted that outdated attribution, incorrect data, lack of aggregated QPR data by site, clinic closures, staffing turnover, limited funding, competing priorities, and provider fatigue related to program changes and delayed payments can make it harder to sustain improvement work.

Summary

Overall, Milestone 2 activities show strong provider engagement and meaningful progress from planning to implementation. Successes are most evident in workflow redesign, coding optimization, care coordination development, EHR enhancements, staff training, and early clinical quality measure improvements. The biggest barriers are data and attribution accuracy, coding and billing complexity, EHR constraints, workforce capacity, and the administrative burden of manual reporting and quality-measure submission. Region 4 practice facilitators will continue helping practices use QPR data, refine workflows, troubleshoot barriers, and sustain improvement efforts in ways that are realistic for each practice setting.

12. Behavioral Health Incentive Program (BHIP)

Colorado Access continues to prioritize improvement in BHIP measures as part of its quality strategy and commitment to improving outcomes for members receiving behavioral health services. Current measures include Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), FUA, Initiation and Engagement of Substance Use Disorder Treatment (IET), and Screening for Depression and Follow-Up Plan for Adults and Children (CDF).

Planned Interventions and Current Successes

Colorado Access has focused on building infrastructure and partnerships to support sustained improvement over time. Real-time behavioral health dashboards remain a key intervention, supporting hospitals, CSNPs, and Colorado Access staff in identifying opportunities for timely follow-up care. These dashboards provide visibility into member transitions and help providers proactively schedule follow-up appointments, monitor performance, and collaborate more effectively. Performance improvement is supported through hospital and CSNP value-based payment programs that align financial incentives with care outcomes. These programs reinforce timely follow-up care, member engagement, and shared accountability between providers.

Provider engagement efforts include structured workgroups, technical assistance, individualized coaching, targeted education, and recurring monthly meetings with CSNPs. These meetings create a consistent forum to review BHIP performance trends, discuss engagement barriers, share best practices, and identify targeted interventions. In addition to monthly meetings, Colorado Access provides focused education on measure expectations, care transition workflows, documentation, and practical strategies providers can use to improve member engagement. A key success has been strengthening provider confidence in using data,

not just to understand performance, but to think critically about what the data means for their workflows, member populations, and opportunities for improvement.

This work has helped shift conversations toward shared problem-solving. Colorado Access works with providers to identify why gaps may be occurring and what operational changes may improve performance. Common areas of focus include appointment availability, member outreach, discharge communication, care coordination workflows, and appropriate information sharing between care settings. This approach allows Colorado Access to describe progress in terms of improved collaboration, stronger use of data, and increased provider engagement, even when specific measure-level results are not included in the narrative.

Colorado Access also continues to strengthen internal quality infrastructure through expanded reporting within Innovaccer, improved governance structures, and use of quality improvement methods through the internal Improvement Academy. These efforts have increased the ability for Colorado Access to monitor performance, identify disparities, coordinate cross-departmentally, and develop targeted interventions that can be refined as additional data becomes available. This work also includes close collaboration with internal business partners such as quality, compliance, UM, care coordination, analytics, and provider-facing teams to ensure interventions are practical, compliant, and aligned across the organization.

Challenges and Barriers

Despite ongoing progress, several challenges continue to affect BHIP performance. Timely follow-up after hospitalization and emergency department visits depends on member engagement, provider appointment availability, and effective communication between care settings. Behavioral health workforce shortages continue to affect capacity and timely scheduling. Data limitations like claims lag, documentation variability, and evolving measure specifications can make it challenging to identify performance gaps in real time. Colorado Access continues to collaborate with BI, analytics, provider partners, and operational teams to improve data accuracy and usability. Provider readiness also varies across the network. Some organizations have robust workflows and QI resources, while others have limited staffing and competing priorities.

Future Plans

Colorado Access plans to build upon existing interventions while continuing to expand behavioral health quality improvement efforts. Priorities include further refinement of performance dashboards, continued monthly CSNP engagement meetings, increased provider outreach and education, enhanced use of stratified data to identify disparities, and additional support for providers participating in quality improvement activities. These planned interventions are intended to strengthen the systems, partnerships, and workflows that drive long-term performance improvement.

A key planned intervention is the hospital engagement strategy, which is designed to strengthen collaboration with inpatient partners and improve transitions of care for members discharged from behavioral health settings. A central component of this strategy will be education for hospitals on BHIP measures, their role in supporting timely follow-up, and the importance of examining internal discharge and referral processes. Colorado Access will also support hospitals in understanding practical coordination steps, including what information may be shared with CSNPs and other outpatient providers under Health Insurance Portability and Accountability Act (HIPAA) and minimum necessary standards, so care teams can communicate effectively while maintaining compliance. Colorado Access will use performance and discharge data to identify hospitals with the greatest opportunity for improvement, engage hospital leadership and operational teams in focused conversations, and clarify shared expectations for timely follow-up after discharge. The goal is to move hospital engagement from transactional outreach to a more collaborative model involving hospitals, CSNPs, outpatient providers, and Colorado Access staff.

Colorado Access care coordination has a strong working relationship with inpatient hospital partners. The care coordination team has designated care coordinators, giving inpatient hospitals a consistent point of contact from the time a member is admitted through discharge. This supports smoother transitions of care and ensures hospitals know who they can contact when coordination needs arise and allows care coordination to assist members with more complex needs. In addition, the team hosts regular interdisciplinary meetings between the RAEs and inpatient hospitals to discuss members who may need additional assistance, identify barriers, and strengthen coordination across care settings.