FY 2022–2023 External Quality Review Technical Report for Child Health Plan *Plus*

January 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acknowledgments and Copyrights

1. Executive Summary

Report Purpose and Overview

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations at Title 42 of the Code of Federal Regulations (42 CFR) §438.356 require states to contract with an external quality review organization (EQRO) to conduct an analysis and evaluation of information generated by the external quality review (EQR)-related activities regarding the quality, timeliness, and accessibility of healthcare services that managed care entities (MCEs) furnish to the State's CHIP members. The end product of this analysis is the annual EQR technical report. The Colorado Department of Health Care Policy & Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to comply with these regulations. This annual EQR technical report includes results of all mandatory and optional EQR-related activities that HSAG conducted with Colorado's Child Health Plan *Plus* (CHP+) health plans throughout fiscal year (FY) 2022–2023.

In FY 2022–2023, the Department contracted with four managed care organizations (MCOs) that provide physical health (PH) primary care, PH and behavioral health (BH) inpatient and outpatient services, and specialty care, and one prepaid ambulatory health plan (PAHP) that provides dental services. Colorado does not exempt any of its CHIP health plans from EQR. The CHP+ health plans that provided services in FY 2022–2023 were Colorado Access (COA), Denver Health Medical Plan, Inc. (DHMP), Kaiser Permanente Colorado (Kaiser), and Rocky Mountain Health Plans (RMHP), which provided PH primary care, PH and BH inpatient and outpatient services, and specialty care and DentaQuest, which provided dental services.

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the Centers for Medicare & Medicaid Services (CMS) EQR Protocols released in October 2019.[1-1] 42 CFR §438.358 also requires the EQRO to aggregate and analyze results in an annual detailed technical report pursuant to §438.364 that summarizes findings on quality, timeliness, and access to care. HSAG presents this report to meet this requirement.

Table 1-1 shows the mandatory and optional EQR-related activities HSAG conducted in FY 2022–2023.

Table 1-1—FY 2022–2023 EQR Activities Conducted

Activity Description/Protocol Number	Participating MCEs
Mandatory Activities	
Validation of Performance Improvement Projects (PIPs) (Protocol 1)	
HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.	CHP+ MCOs and CHP+ PAHP
HEDIS/CMS Core Set Measure Rate Validation (Protocol 2)	
To assess the accuracy of the performance measures reported by or on behalf of the MCEs, each MCE's licensed HEDIS auditor validated each performance measure selected by the	CHP+ MCOs and CHP+ PAHP

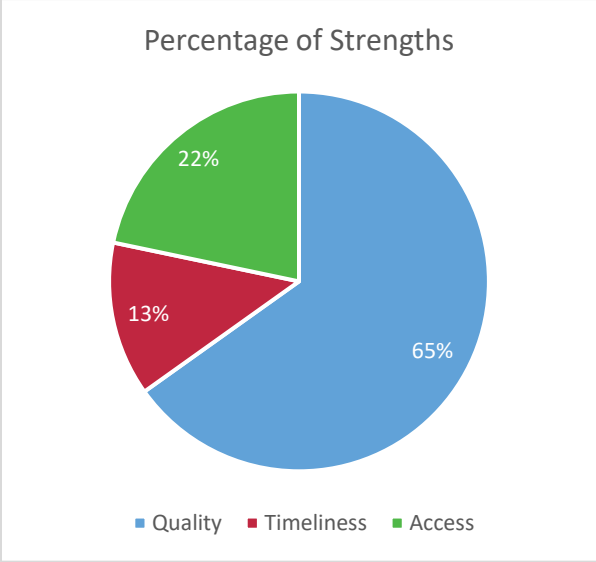
[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 7, 2023.

Activity Description/Protocol Number	Participating MCEs
Department for review. The validation also determined the extent to which performance measures calculated by the MCEs followed specifications required by the Department.	
Assessment of Compliance With CHIP Managed Care Regulations (Compliance With Regulations) (Protocol 3)	
Compliance activities were designed to determine the MCEs' compliance with State and federal managed care regulations and related Department contract requirements.	CHP+ MCOs and CHP+ PAHP
Validation of Network Adequacy (NAV) (Protocol 4)	
Each quarter, HSAG validated each MCE's self-reported compliance with minimum time and distance network requirements and collaborated with the Department to update network adequacy reporting materials used by the health plans. For the provider directory validation (PDV) activity, HSAG validated the MCEs' online provider directories to determine if the information matched the provider data submitted to HSAG by the MCEs.	CHP+ MCOs and CHP+ PAHP
Optional Activities	
CAHPS Surveys (Protocol 6)	
HSAG annually administers the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set to parents/caretakers of child members enrolled in Colorado's CHP+ MCOs.	CHP+ MCOs
EQR Dashboard (Protocol 9)	
HSAG designed the EQR Dashboard to allow the Department to monitor and track the MCEs' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, and PIPs.	CHP+ MCOs and CHP+ PAHP
Quality of Care (QOC) Grievances and Concerns Audit (Protocol 9)	
HSAG conducted an audit of the MCEs to evaluate processes for managing, investigating, and resolving QOC grievances and concerns.	CHP+ MCOs and CHP+ PAHP

Summary of FY 2022–2023 Statewide Performance Related to Quality, Timeliness, and Access

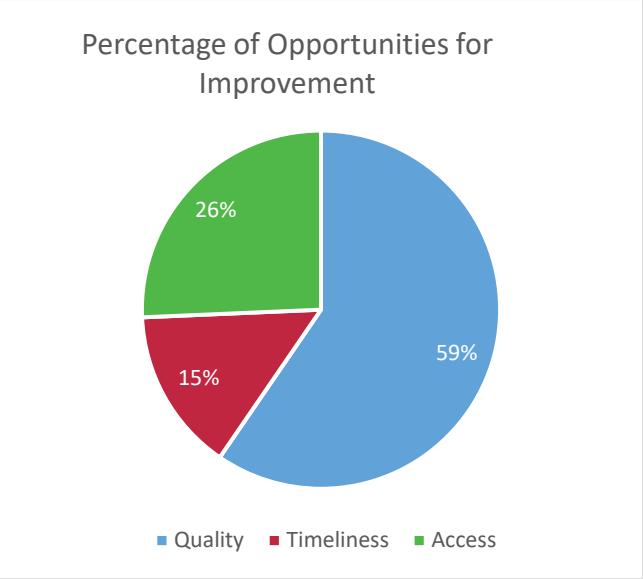
Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weaknesses (opportunities for improvement) that HSAG assessed as likely to impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted for all Colorado CHP+ health plans during FY 2022–2023.

Figure 1-1—Percentage of Strengths*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 1-2—Percentage of Opportunities for Improvement*



**Each opportunity for improvement may impact one or more domains of care (quality, timeliness, or access).*

Statewide Recommendations Related to Quality, Timeliness, and Access

The CHP+ health plans demonstrated moderate to strong compliance and performance for EQR activities such as Validation of Performance Improvement Projects, Assessment of Compliance With CHIP Managed Care Regulations, and Validation of Network Adequacy. HSAG identified opportunities for improvement in the HEDIS/CMS Core Set Measure Rate Validation and CAHPS Surveys EQR activities. As each EQR activity is comprised of multiple strengths and opportunities for improvements, HSAG noted the CHP+ health plans' strengths ranged from 18 to 30 strengths. The CHP+ health plan with the most strengths had the lowest number of opportunities for improvement.

For detailed statewide findings and recommendations see Section 3—Statewide Comparative Results, Assessment, Conclusions, and Recommendations. For detailed CHP+ health plan-specific findings and recommendations, see Section 4—Evaluation of Colorado's CHP+ Health Plans.

2. Reader's Guide

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, includes provisions to implement CHIP, a program funded jointly by the State and federal governments. CHP+ is Colorado's implementation of federal CHIP regulations. In May 2016, the final Medicaid and CHIP managed care regulations articulated in 42 CFR Part 438, cross referenced in 42 CFR Part 457, brought consistency between the Medicaid and CHIP regulations. The final rule, with revisions published in December 2020, requires states that contract with MCOs and PAHPs (collectively referred to as "health plans" or "MCEs") for the administration of CHIP programs to contract with a qualified EQRO to provide an independent EQR of the quality, timeliness, and accessibility of services provided by the contracted health plans. To meet the requirements for EQR, the Department has contracted with HSAG, a qualified EQRO.

HSAG recognizes that EQR-related activities in FY 2020–2021 and, to a lesser extent, FY 2021–2022 were conducted during the unprecedented coronavirus disease 2019 (COVID-19) public health emergency (PHE); therefore, trending and comparisons to the FY 2020–2021 and FY 2021–2022 results of the EQR activities in this report, particularly in the access to care domain, should be considered with caution. Regardless, while some health plans experienced lower scores across domains of care across these two reporting years, Colorado's CHP+ health plans also found innovative and creative ways to address barriers and continued to provide services for Colorado's CHP+ members.

How This Report Is Organized

Section 1—Executive Summary provides the purpose and overview of this annual EQR technical report, includes a brief introduction to the CHP+ program, and describes the authority under which Colorado's MCEs provide services. This section also describes the EQR activities conducted during FY 2022–2023 and includes graphics that depict the percentages of strengths and opportunities for improvement—derived from conducting mandatory and optional EQR activities in FY 2022–2023—that relate to the care domains of quality, timeliness, and access. In addition, this section includes any conclusions drawn and recommendations made for statewide performance improvement.

Section 2—Reader's Guide describes the background of federal regulations and the authority under which the report must be provided; an overview of the methodology for each EQR activity performed; and how HSAG obtained, aggregated, and used the data obtained to draw conclusions as to the quality, timeliness, and accessibility of care provided by Colorado's CHP+ health plans.

Section 3—Statewide Comparative Results, Assessment, Conclusions, and Recommendations includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results for each CHP+ health plan and statewide averages. This section identifies, through presentation of results for each EQR activity, statewide trends and commonalities used to derive statewide conclusions and recommendations. In addition, this section includes an assessment of how the Department can target the goals and objectives of the State's Managed Care Quality Strategy to better

support the improvement of the quality, timeliness, and accessibility of healthcare provided by the CHP+ health plans.

Section 4—Evaluation of Colorado's CHP+ Health Plans provides summary-level results for each EQR activity performed for the CHP+ health plans in FY 2022–2023. This information is presented for each CHP+ health plan and provides an activity-specific assessment of the quality, timeliness, and accessibility of care and services for each health plan as applicable to the activities performed and results obtained. This section also provides for each health plan, by EQR activity, an assessment of the extent to which each health plan was able to follow up on and complete any recommendations or corrective actions required as a result of the FY 2021–2022 EQR-related activities.

Appendix A—CHP+ Administrative and Hybrid Rates presents results for measure rates with a hybrid option for the two CHP+ MCOs that chose to submit using both administrative and hybrid methods. The MCEs were only required to report administrative rates for measures with a hybrid option.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the CHP+ health plans in each of the domains of quality, timeliness, and access to care and services.

Quality

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

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2]

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] Ibid.
[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that any reported improvement is related, and can reasonably be linked to, the quality improvement (QI) strategies and activities the health plans conducted during the PIP. HSAG's scoring methodology evaluated whether the health plan executed a methodologically sound PIP.

Technical Methods of Data Collection

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of Plan-Do-Study-Act (PDSA) cycles, and applying rapid-cycle learning principles over the course of the PIP to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

For this PIP framework, HSAG use four modules with an accompanying reference guide to assist health plans in documenting PIP activities for validation. Prior to issuing each module, HSAG holds technical assistance sessions with the health plans to educate about application of the modules. The four modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the health plan sets aims

(Global and SMART [Specific, Measurable, Achievable, Relevant, Time-Bound]), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.

- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the QI activities reasonably expected to impact the SMART Aim. The health plan updates the key driver diagram from Module 1 after completing process mapping, failure mode and effects analysis (FMEA), and failure mode priority ranking for a more in-depth understanding of the improvement strategies that are most likely to support achievement of the SMART Aim goal.
- **Module 3—Intervention Testing:** In Module 3, the health plan defines the intervention plan for the intervention to be tested, and the intervention effectiveness measure and data collection process are defined. The health plan will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, the health plan summarizes key findings, compares successful and unsuccessful interventions, and reports outcomes achieved. The health plan will synthesize data collection results, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement after the project ends.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission forms. In FY 2022–2023, these forms provided detailed information on the PIPs and the activities completed for Module 4—PIP Conclusions.

Following HSAG's rapid-cycle PIP process, the health plans submitted each module according to the approved timeline. Following the initial validation of each module, HSAG provided feedback and technical assistance to the health plans, and the health plans resubmitted a revised Module 4, if needed.

HSAG's module submission forms allowed the health plans to document the data collection methods used to obtain PIP measure results for monitoring improvement achieved through each PIP. Table 2-1 summarizes the performance indicator description and data sources used by each health plan for the PIPs.

Table 2-1—FY 2021–2022 CHP+ PIP SMART Aim Statements and Data Sources

Health Plan	SMART Aim	Data Sources
COA	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in well visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.36% to 41.14%.	Claims and enrollment data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of *Follow-up After a Positive Depression Screen* visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers from 73.58% to 90.57%.	Claims and enrollment data

Health Plan	SMART Aim	Data Sources
DHMP	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH [patient-centered medical home], from 62.11% to 70.18%.	Enrollment data, claims data, and electronic medical record (EMR) data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH from 55.56% to 81.48%.	Enrollment data, claims data, and EMR data
Kaiser	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs [medical office buildings] between the ages 12 and 17 who are screened for depression annually from 14.22% to 25.00%. This will be achieved by utilizing key driver diagram interventions.	Enrollment and EMR data
	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12–17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.	Enrollment and EMR data
RMHP	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP members 12 years of age or older from 2.0% to 25.0%.	Claims and enrollment data
	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP members 12 years of age or older who screen positive for depression that are successfully connected to appropriate BH services within 30 days to the established benchmark of 46.89%.	Claims and enrollment data
DentaQuest	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members aged 3–5 who reside in Weld County, from 45.47% to 49.30%.	Claims and enrollment data

How Data Were Aggregated and Analyzed

Using its rapid-cycle PIP validation tools for each module, HSAG scores each PIP on a series of evaluation elements and scores each evaluation element for modules 1 and 2 as *Met* or *Not Met*. A health plan must receive a *Met* score on all applicable evaluation elements for modules 1 through 3 before progressing on to the next phase of testing interventions through PDSA cycles and reporting PIP conclusions in Module 4. Once the health plan completes intervention testing and submits Module 4 and the completed PDSA worksheets for validation, HSAG reviews the PDSA worksheet documentation and score evaluation elements for Module 4 as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigns a level of confidence to the PIP after completing validation of Module 4 submission.

How Conclusions Were Drawn

HSAG, as the State's EQRO, validates the PIPs through an independent review process. In its PIP evaluation and validation, HSAG uses CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-1]

During validation, HSAG determines if criteria for each module were *Met*. Any validation criteria not applicable are not scored. As the PIP progresses, HSAG uses the validation findings from modules 1 through 4 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigns a level of confidence and reports the overall validity and reliability of the findings as one of the following:

- ***High confidence:*** The PIP was methodologically sound; the SMART Aim goals achieved statistically significant, clinically significant, or programmatically significant improvements for both measures; at least one tested intervention for each measure could reasonably result in the demonstrated improvement; and the health plan accurately summarized the key findings and conclusions.
- ***Moderate confidence***: The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:
  - The SMART Aim goal achieved statistically significant, clinically significant, or programmatically significant improvement *for only one measure*, and the health plan accurately summarized the key findings and conclusions.
  - Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure* and the health plan accurately summarized the key findings and conclusions.
  - The SMART Aim goal achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement *for at least one measure*; however, the health plan *did not* accurately summarize the key findings and conclusions.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 7, 2023.

- ***Low confidence***: One of the following occurred:
  - The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.
  - The PIP was methodologically sound. The SMART Aim goal achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.
  - The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.
- ***No confidence:*** The SMART Aim measures and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the CHP+ health plans, HSAG assigned each of the projects reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG determined that all PIPs were related to the quality domain. The Department selected the state-mandated PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*, for all health plans, except DentaQuest. In addition to addressing the quality domain, the state-mandated topic (access to depression screening and follow-up BH services) addressed access to care and timeliness of care (receiving timely follow-up BH services after a positive depression screen). DentaQuest selected a different topic relevant to the scope of services it provides as a dental PAHP, which also addressed access to dental care, in addition to addressing the quality domain. The assignment of domains for each PIP is shown in Table 2-2.

Table 2-2—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

Health Plan	Performance Improvement Project	Quality	Timeliness	Access
COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
Kaiser	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
DentaQuest	*Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*	✓		✓

Validation of Performance Measures

Objectives

The primary objectives of the performance measure validation (PMV) process were to:

- Evaluate the accuracy of performance measure data calculated by the MCE.
- Determine the extent to which the specific performance measures calculated by the MCE (or on behalf of the MCE) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

Each MCE had existing business relationships with NCQA Licensed Organizations (LOs) that conducted HEDIS audits for their lines of business (LOBs). The Department allowed the MCEs to use their existing NCQA LOs to conduct the audit in line with HEDIS Compliance Audit policies and procedures. The HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the MCEs processes than do the requirements for validating performance measures as set forth by CMS. Therefore, using the HEDIS audit methodology complied with both NCQA and CMS specifications, allowing for complete and reliable evaluation of the MCEs. HSAG requested copies of the final audit report (FAR) for each MCE and aggregated sources of HEDIS-related data to confirm that the MCE met the HEDIS Information Systems (IS) standards and had the ability to report HEDIS data accurately.

The following processes and activities constitute the standard practice for HEDIS audits in measurement year (MY) 2022, regardless of the auditing firm. These processes and activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[2-2]

- Teleconference calls with the MCE's personnel and vendor representatives, as necessary.
- Detailed review of the MCE's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- Virtual site review meetings or Webex conferences, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS and non-HEDIS measure data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification (PSV).
  - Programming logic review and inspection of dated job logs.

[2-2] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS and non-HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the MCE's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the MCE's HEDIS and non-HEDIS measure data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS and non-HEDIS MY 2022 rates as presented within the custom rate reporting template completed by the MCE's contractor.

The MCEs were responsible for obtaining and submitting their respective HEDIS FARs to HSAG. The auditor's responsibility was to express an opinion on each MCE's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the MCEs, it did review the audit reports produced by the other LO's and determined all IS standards were met.

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for HEDIS MY 2022 as part of the validation of performance measures:

1. **FARs:** The FARs, produced by the MCEs' LOs, provided information on the MCEs' compliance to IS standards and audit findings for each measure required to be reported.
2. **Measure Certification Report:** The vendor's measure certification report was reviewed to confirm that all required measures for reporting had a "pass" status. Additionally, if applicable, all HEDIS measures where CMS Core Set stratifications differed from HEDIS and all non-HEDIS measures' source code were reviewed and approved.
3. **Rate Files from Previous Years and Current Year:** Final rates provided by MCEs in a custom rate reporting template were reviewed to determine trending patterns and rate reasonability. Please note that all rates HSAG included in this report were those rates according to the federal fiscal year (FFY) 2023 CMS Adult and Child Core Set specifications. Age stratifications for the Core Set measures may differ from HEDIS age stratifications.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the audited HEDIS results submitted to the Department by the MCEs, which included each MCE's FAR and custom rate reporting template. HSAG used the final audit results and the FAR as the primary data sources to tabulate overall reporting capabilities and functions for the MCEs. The final audit results provided the final determinations of validity made by the MCE's LO auditor for each performance measure. The FAR included information on the MCE's IS capabilities, findings for each measure, MRR validation results, results of any corrected programming logic

(including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement.

The MCEs' measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a p value < 0.05. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the custom reporting template files for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure.[2-3] This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the specific size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for MCO 1
R_1 = the rate for MCO 1
P_2 = the eligible population for MCO 2
R_2 = the rate for MCO 2

Measure results for MY 2022 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2021. In the performance measure results tables, an em dash (—) indicates that the rate is not presented in this report as the Department did not require the MCEs to report this rate for the respective submission or NCQA recommended a break in trending in MY 2022. This symbol may also indicate that a percentile ranking was not determined, either because the MY 2022 measure rate was not reportable or because the measure did not have an applicable benchmark.

Additionally, the following logic determined the high- and low-performing measure rates discussed within the results:

- High-performing rates are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:

[2-3] DentaQuest was required to calculate and report dental services-specific rates; therefore, DentaQuest rates are not included in any statewide rates.

  - Ranked at or above the 75th percentile without a statistically significant decline in performance from HEDIS MY 2021.
  - Ranked between the 50th and 74th percentiles with statistically significant improvement in performance from HEDIS MY 2021.
- Low-performing rates are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Ranked below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with statistically significant decline in performance from HEDIS MY 2021.

Based on the Department's guidance, all measure rates presented in this report for the MCEs are based on administrative data only. The Department required that all MY 2020, MY 2021, and MY 2022 measures be reported using the administrative methodology only. However, DHMP and RMHP still reported certain measures to NCQA using the hybrid methodology. The hybrid measures' results are found in Table A-1 in Appendix A. When reviewing measure results, the following items should be considered:

- MCEs that were able to obtain supplemental data or capture more complete data will generally report higher rates when using the administrative methodology. As a result, the measure rates presented in this report for measures with a hybrid option may be more representative of data completeness rather than a measure of performance. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks or to prior years' results that were established using administrative and/or MRR data, as results likely underestimate actual performance. Table 2-3 presents the measures provided in the report that can be reported using the hybrid methodology.

Table 2-3—Core Set Measures That Can Be Reported Using the Hybrid Methodology

Measures
Primary Care Access and Preventive Care
Childhood Immunization Status
Developmental Screening in the First Three Years of Life
Immunizations for Adolescents
Lead Screening in Children
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Maternal and Perinatal Health
Prenatal and Postpartum Care

- National HEDIS percentiles are not available for the CHIP population. Comparison of the CHP+ MCOs' rates to Medicaid percentiles should be interpreted with caution.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the CHP+ MCEs, HSAG determined that each of the indicators validated were related to one or more of the three domains of care (quality, timeliness, or access). This relationship of the measures to the domains of care is depicted in Table 2-4.

Table 2-4—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Primary Care Access and Preventive Care			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Chlamydia Screening in Women	✓		
Colorectal Cancer Screening	✓	✓	✓
Immunizations for Adolescents	✓		
Lead Screening in Children	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Maternal and Perinatal Health			
Contraceptive Care—All Women	✓	✓	✓
Contraceptive Care—Postpartum Women	✓	✓	✓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	✓	✓	✓
Care of Acute and Chronic Conditions			
Asthma Medication Ratio	✓		
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years	✓		
Behavioral Health Care			
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Screening for Depression and Follow-Up Plan	✓		✓

Performance Measure	Quality	Timeliness	Access
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Services			
Ambulatory Care: Emergency Department Visits	NA	NA	NA
Dental and Oral Health Services			
Oral Evaluation, Dental Services	✓	✓	✓
Topical Fluoride for Children	✓	✓	✓
Sealant Receipt on Permanent First Molars	✓	✓	✓

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

Information Systems Standards Review

The MCEs must be able to demonstrate compliance with IS standards. The MCEs' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCE compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in Section 4, MY 2020, MY 2021, and MY 2022 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for MY 2020, MY 2021, and MY 2022, a measure result of *Small Denominator* (*NA*) indicates that the MCE followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the MCE chose not to report the measure.

Assessment of Compliance With CHIP Managed Care Regulations

HSAG divided the federal regulations into 12 standards consisting of related regulations and contract requirements. Table 2-5 describes the standards and associated regulations and requirements reviewed for each standard. Of note, Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services does not apply to the CHP+ program. HSAG reviews four standards each fiscal year.

Table 2-5—Compliance Standards

Standard Number and Title	Regulations Included	Years Reviewed
Standard I—Coverage and Authorization of Services	438.114 438.210	2016–2017, 2019–2020, 2022–2023
Standard II—Adequate Capacity and Availability of Services	438.206 438.207	2013–2014, 2016–2017, 2019–2020, 2022–2023
Standard III—Coordination and Continuity of Care	438.208	2015–2016, 2018–2019, 2021–2022
Standard IV—Member Rights, Protections, and Confidentiality	438.100 438.224	2015–2016, 2018–2019, 2021–2022
Standard V—Member Information Requirements	438.10	2017–2018, 2020–2021
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424	2017–2018, 2020–2021, 2022–2023
Standard VII—Provider Selection and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610	2017–2018, 2020–2021

Standard Number and Title	Regulations Included	Years Reviewed
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines	2015–2016, 2018–2019, 2021–2022
Standard IX—Subcontractual Relationships and Delegation	438.230	2017–2018, 2020–2021
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	438.236 438.240 438.242	2015–2016, 2018–2019, 2021–2022
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280	NA Does not apply to the CHP+ program
Standard XII—Enrollment and Disenrollment	438.3(d) 438.56	2022–2023

For the FY 2022–2023 compliance review process, the standards reviewed were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each compliance review was to provide meaningful information to the Department and the health plans regarding:

- The health plans' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the health plans into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality, timeliness, and accessibility of care and services furnished by the health plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the health plans' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess for health plans' compliance with regulations, HSAG conducted the five activities described in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-4] Table 2-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-6—Protocol Activities Performed for Assessment of Compliance With Regulations

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	The Department directed HSAG to conduct all compliance monitoring activities virtually. HSAG used web-based conferencing to conduct the FY 2022–2023 compliance reviews. All protocol activities, requirements, and agendas were followed. Before the virtual compliance review designed to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, record review tools, report templates and virtual review agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the interview portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and a compliance review agenda. The document request included instructions for organizing and preparing the documents related to the review of the four standards and record reviews. Thirty days prior to each scheduled compliance review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the virtual portion of the review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 7, 2023.

For this step,	HSAG completed the following activities:
	materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the interview portion of the review and prepared a request for further documentation, if needed, as well as an interview guide for HSAG's use during the review.
Activity 3:	**Conduct Virtual Compliance Review**
	• During the interview portion of the review, HSAG met with each health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG also requested and reviewed additional documents as needed, based on interview responses. • At the close of the interview portion of the review, HSAG met with the health plan's staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved compliance review report template to compile the findings and incorporate information from all compliance review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the compliance review report to the health plans and the Department for review and comment. • HSAG incorporated the health plans' and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plans and the Department.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider contracts, agreements, manuals, and directories
- Member handbook and informational materials

- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks
- Interviews with key health plan staff members conducted virtually

How Data Were Aggregated and Analyzed

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, virtual interviews conducted with key health plan personnel, and any additional documents submitted as a result of the interviews. HSAG then calculated scores; analyzed scores, looking for patterns of compliance and noncompliance; and compared scores to the health plans' previous performance, looking for trends. HSAG developed statewide tables of performance (see Section 3) to conduct comparisons of health plans and determine if commonalities of performance existed within the review period, and developed long-term comparison of standard scores over the three-year cycle (where available) to determine if the health plans' overall compliance improved across multiple review cycles.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the CHP+ health plans, HSAG determined that each standard reviewed for assessment of compliance with regulations was related to one or more of the domains of care (quality, timeliness, or access). Each standard may involve assessment of more than one domain of care due to the combination of individual requirements in each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or accessibility of care and services provided by the health plans. Table 2-7 depicts the relationship between the standards and the domains of care.

Table 2-7—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Adequate Capacity and Availability of Services	✓	✓	✓
Standard VI—Grievance and Appeal Systems	✓	✓	
Standard XII—Enrollment and Disenrollment	✓		✓

Validation of Network Adequacy

HSAG conducted two distinct activities in FY 2022–2023 designed to assist the Department in understanding the adequacy of the provider networks across the state: time and distance analysis and PDV.

Objectives

Time and Distance Analysis

The purpose of the FY 2022–2023 network adequacy validation (NAV) time and distance analysis was to determine the extent to which HSAG agreed with the MCEs' self-reported compliance with minimum time and distance network requirements applicable to each MCE. CMS recently released the EQR NAV protocol in February 2023. While the FY 2022–2023 NAV activity was designed to be a robust validation of Colorado's network adequacy and was executed in alignment with the federal regulations in place at the time of the activity, the contents of this report do not reflect activities described in the recently published CMS protocols. The activities described in the protocol must be implemented beginning in February 2024 and included in the analysis for the EQRO technical reports due in April 2025.

Provider Directory Validation

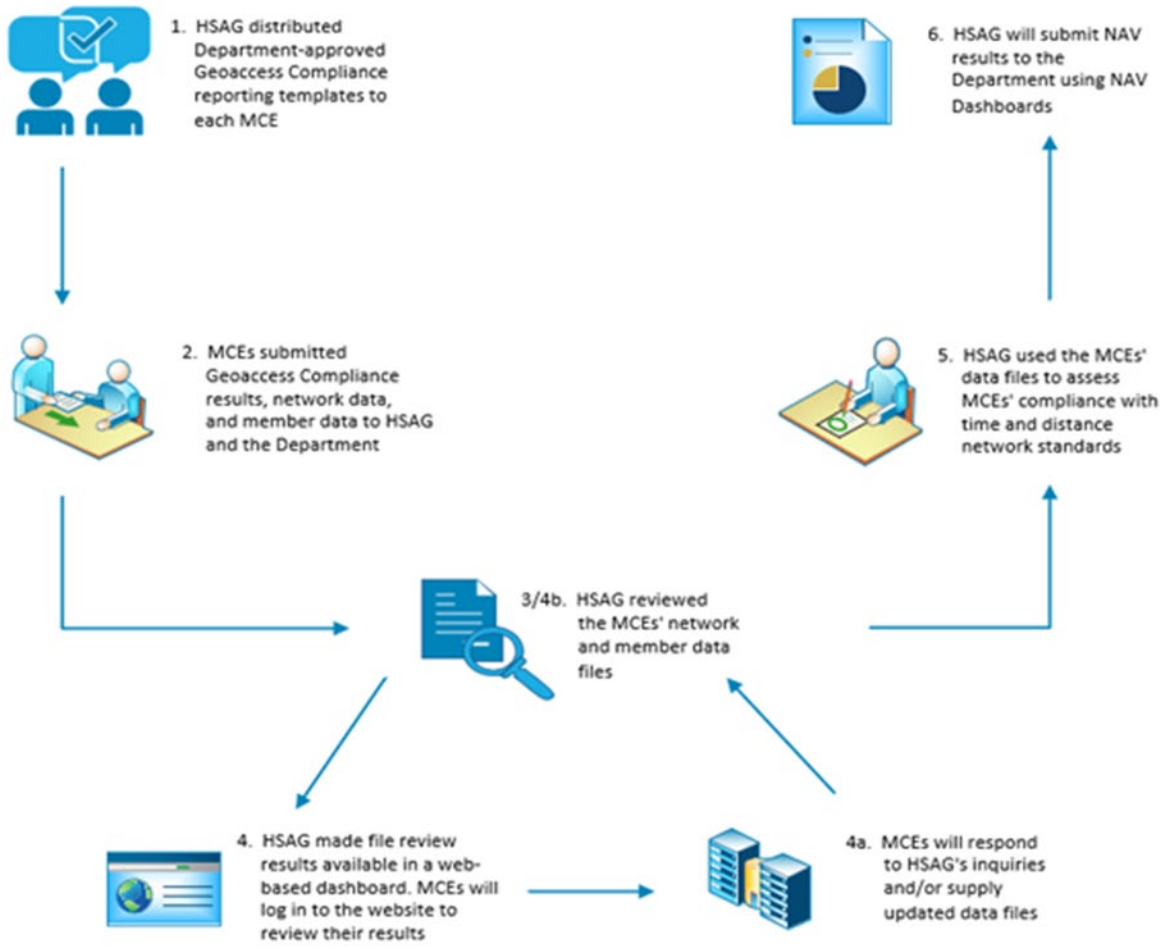
The goal of the FY 2022–2023 PDV was to determine if the information on the MCEs' online provider directories matched the provider data submitted to HSAG by the MCEs.

Technical Methods of Data Collection

Time and Distance Analysis

Beginning in the upper left corner, Figure 2-1 describes the key steps in HSAG's process for quarterly NAV time and distance analysis.

Figure 2-1—Summary of FY 2022–2023 NAV Process for Time and Distance Analysis



** HSAG's validation results reflect the MCEs' member and network data submissions, and the Department also supplied network and member data to HSAG for comparison with the MCEs' data.*

HSAG provided the Department-approved geoaccess compliance templates and requested provider network and member data from each MCE. HSAG reviewed each CHP+ MCE's provider network and member data, iteratively requesting clarifications of data-related questions or updated data files. Once clarified and updated as needed, HSAG performed the network adequacy analyses to assess the CHP+ MCEs' compliance with minimum time and distance standards. HSAG also developed the network adequacy dashboards for internal use by the Department in QI activities.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the quarterly network adequacy report templates. The provider types (e.g., physician, medical doctor) and specialties (e.g., cardiology, family medicine) listed in the Network Crosswalk are based on MCE data values observed by HSAG. Each MCE was instructed to review its network data values to ensure alignment with the Department's provider categories (e.g., Pediatric Primary Care Practitioner [Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), nurse practitioner (NP),

clinical nurse specialists (CNS)], General Behavioral Health). Analyses and templates included, at a minimum, network categories aligned with the Department's managed care Network Crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[2-5,2-6] Table 2-8 presents the provider categories applicable to CHP+ MCEs; within each category, FY 2022–2023 NAV analyses were limited to categories corresponding to the MCEs' minimum time and distance network requirements.

Table 2-8—Provider Categories by MCE Type

Network Domain	CHP+ MCOs	PAHP
Primary Care, Prenatal Care, and Women's Health Services	✓	
Physical Health Specialists	✓	
Behavioral Health	✓	
Physical Health Entities (*Acute Care Hospitals, Pharmacies*)	✓	
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	✓	
Dental Services (*Primary Dental Care and Specialty Services*)		✓

In FY 2022–2023, HSAG collaborated with the Department to enhance and maintain the Network Crosswalk and quarterly network adequacy reporting materials, with the goal of standardizing the CHP+ MCEs' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the MCEs' network adequacy results. On December 15, 2022, HSAG notified each MCE of the January 31, 2023, deadline to submit the FY 2022–2023 Quarter 2 (Q2) network adequacy report and data files. Each MCE's notification included detailed data requirements and a MCE-specific Network Adequacy Quarterly Geoaccess Results Report template containing the MCE's applicable network requirements and contracted counties. To support consistent network definitions across the CHP+ MCEs and over time, HSAG supplied the CHP+ MCEs with the Department-approved December 2022 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

Concurrent with requesting the CHP+ MCEs' network and member data, HSAG requested CHP+ member and network files from the Department for members enrolled with a MCE and practitioners,

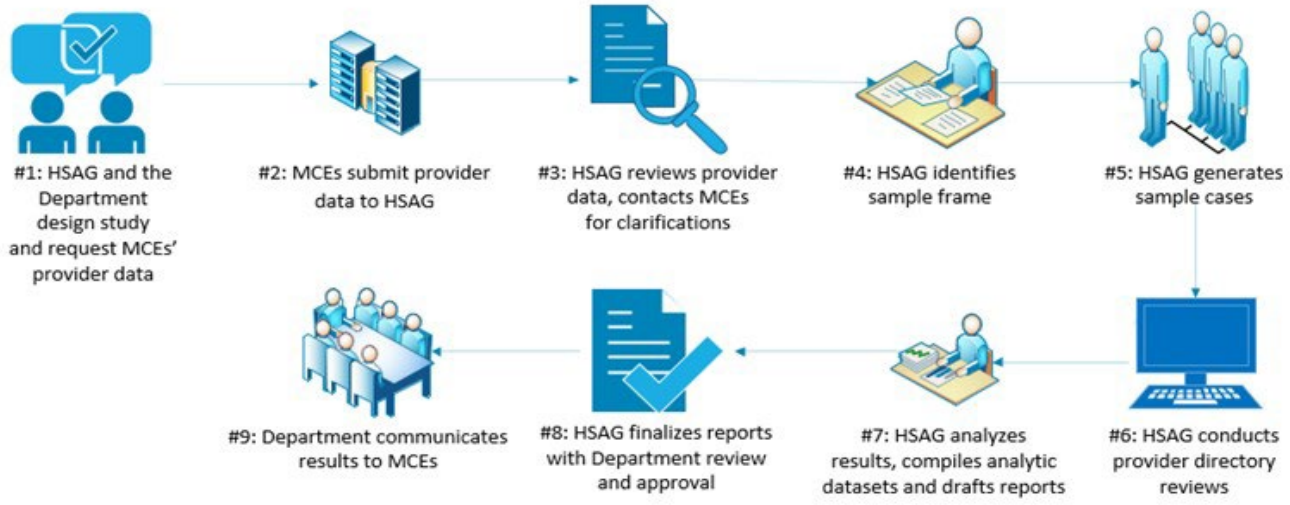
2-5 Network Adequacy Standards, 42 CFR §438.68. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=d748c4b2039bd7ac516211b8a68e5636&mc=true&node=se42.4.438_168&rgn=div8. Accessed on: Dec 13, 2023.

2-6 The federal network adequacy standard lists the following provider categories that represent common types or specialties of healthcare providers generally needed within a Medicaid population: primary care, adult and pediatric; obstetrics/gynecology (OB/GYN); BH (mental health and SUD), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

practices, and entities enrolled in *interChange*.[2-7] HSAG requested CHP+ member files from the Department using a detailed member data requirements document for members actively enrolled with a MCE as of December 31, 2022, for FY 2022–2023 Q2. During FY 2022–2023, HSAG used the Department's member data and network data each quarter within the enhanced file review process to assess the completeness of the MCEs' member data submissions (e.g., comparing the number of members by county between the two data sources).

Provider Directory Validation

Figure 2-2—Summary of FY 2022–2023 Process for PDV



Using the October 31, 2022, quarterly provider data file, which represented practitioners that were actively enrolled in the CHP+ program as of September 30, 2022, HSAG sampled 411 practitioners (i.e., "cases") for each MCE from the eligible population. Cases were sampled by unique provider and address (i.e., validation was performed for a provider for the sampled location), and only counties in which each MCE had attributed members were included.

Description of Data Obtained

Time and Distance Analysis

Quantitative data for the study included member-level data from the Department and member and provider network data files data from each CHP+ MCE, which included data values with provider attributes for type (e.g., NP), specialty (e.g., family medicine), credentials (e.g., licensed clinical social

[2-7] *interChange* is the Department's Medicaid Management Information System (MMIS). All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs.

worker), and/or taxonomy code. Concurrent with requesting the MCEs' network and member data, HSAG requested the CHP+ MCEs' member and provider network files from the Department for members enrolled with an MCE and practitioners, practices, and entities enrolled in *interChange*.

During the FY 2022–2023 NAV, HSAG also used the Department's member data to compare against the CHP+ MCEs' member data files (e.g., demographic information and member counts).

Provider Directory Validation

HSAG used the October 31, 2022, quarterly provider data file, which represented practitioners that were actively enrolled in the Health First Colorado program as of September 30, 2022, to select the PDV samples. The following specialty categories[2-8] were eligible for sampling for each MCE.

Adult and Pediatric:

- General Behavioral Health (BV102, BV103, BV104, BV120, BV121, BV130, BV131, BV132, BG126, BG127)
- Psychiatric and other Psychiatric Prescribers (BV100, BV101, BG110, BG111, BG112)
- Substance Use Disorder (SUD) Treatment Practitioners (BV080)
- SUD Treatment Facilities (all American Society of Addiction Medicine (ASAM) levels of care [LOCs]) (BF085)
- Psychiatric Hospitals, Units and Acute Care (BF140, BF141)

How Data Were Aggregated and Analyzed

Time and Distance Analysis

HSAG used the MCEs' member and provider network data to calculate time/distance and compliance mismatch results for each MCE for each county in which the MCE had at least one member identified in the MCE's member data file during FY 2022–2023. HSAG evaluated two dimensions of access and availability: compliance mismatch (i.e., HSAG did not agree with the MCE's quarterly geoaccess compliance results) and geographic network distribution analysis (i.e., time and distance metrics). HSAG calculated these metrics for the network categories for which the Department identified a minimum time and distance access requirement prior to initiation of the analysis.

Prior to analysis, HSAG assessed the completeness and validity of selected data fields critical to the NAV analyses from the MCEs' member and provider network data files. Within the MCEs' provider network and member data files, HSAG conducted a variety of validation checks for fields pertinent to the time and distance calculations, including the following:

- Evaluating the extent of missing and invalid data values.

[2-8] The network category codes that were used to identify each provider type are included in parentheses.

- Compiling the frequencies of data values.
- Comparing the current data to the MCEs' prior quarterly data submissions.

HSAG also used the Department's member data to assess the completeness and reasonability of the MCEs' member data files (e.g., assessing the proportion of members residing outside of a MCE's assigned counties and comparing the results to prior quarters' data). Following initial data quality review, HSAG refreshed the network adequacy data initial validation (NADIV) dashboard with data results quarterly. Each MCE was provided access to the NADIV dashboard, an interactive tool through which the initial file review findings were summarized. Alongside the summary of findings, HSAG stated whether clarifications and/or data file resubmissions were required.

Following the initial data review and HSAG's receipt of the MCEs' data resubmissions and/or clarifications, HSAG geocoded the member and network addresses to exact geographic locations (i.e., latitude and longitude). Geocoded member and network data were assembled and used to conduct plan type-specific analyses using the Quest Analytics Suite Version 2023.1 software (Quest). HSAG used Quest to calculate the duration of travel time or physical (driving) distance between the members' addresses and the addresses of the nearest provider(s) for the selected network categories.

Consistent with the Department's instructions to the MCEs, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[2-9] HSAG used the counties listed in the MCEs' member data files to attribute each member to a Colorado county for the county-level time and distance calculations (i.e., the number and percentage of members residing in the specified county with a residential address within the minimum time or distance requirement for the specific network requirement among all applicable providers, regardless of the providers' county). For MCE member records missing the county information, HSAG used the county identified by Quest if the address was an exact match during the geocoding process. Members that could not be attributed to a Colorado county were excluded from the NAV analyses.

Provider Directory Validation

For each sampled case, HSAG compared the MCEs' provider data values to the information on the MCEs' online provider directory for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Practitioner's Name or Business Name
- Address: Street Address
- Address: Suite Number
- Address: City
- Address: State

[2-9] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2022. Available at: https://coruralhealth.org/wp-content/uploads/2013/10/2022-county-designations.pdf. Accessed on: Nov 7, 2023.

- Address: ZIP Code
- Telephone Number
- Practitioner Type/Specialty (matches the sampled practitioner specialty category)
- Accepting New Patients
- Practitioner Gender[2-10]

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the quarterly provider data extract.
- No, the information did not match between the online provider directory and the quarterly provider data extract.
- Not listed in directory, the information was listed in the MCE provider data, but not listed in the online provider directory. This response applied to the following indicators: practitioner type/specialty, accepting new patients, and practitioner gender.

How Conclusions Were Drawn

Time and Distance Analysis

HSAG used the CHP+ MCEs' quarterly geoaccess compliance reports and member and provider data to perform the geoaccess analysis specific to each MCE. HSAG reviewed the results of the compliance mismatch analysis to identify the percentage of results where HSAG agreed with the MCE's geoaccess compliance results, stratified by county designation. HSAG reviewed the results of the analysis of time and distance requirements to report the percentage of results within the time and distance network requirements, and the percentage of results that did not meet the time and distance requirements.

HSAG determined that the NAV activities provided insight into the access domain of care.

Provider Directory Validation

To draw conclusions about the quality and accessibility of care and services that each MCE provides to its members, HSAG analyzed the results of the PDV activity to determine each MCE's strengths and weaknesses by assessing the degree to which the MCEs' online provider directory information is accurate, up-to-date, and easy to locate and navigate.

[2-10] The "Practitioner Gender" indicator was not assessed for facilities.

CAHPS Surveys

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding regarding patients' and parents'/caretakers' of child patients experiences with the healthcare they/their child received.

Technical Methods of Data Collection

HSAG administered the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the Children with Chronic Conditions [CCC] measurement set) for the CHP+ population. Parents/caretakers of child members included as eligible for the survey were 17 years of age or younger as of October 31, 2022. All parents/caretakers of sampled members completed the surveys from December 2022 to May 2023. The first phase consisted of an English or Spanish version of the cover letter being mailed to the parents/caretakers of all sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. The cover letters included a toll-free number that parents/caretakers could call to request a survey in the other language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a second reminder postcard. The second phase, or telephone phase, consisted of computer-assisted telephone interviewing (CATI) of parents/caretakers of sampled child members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent at different times of the day, on different days of the week, and in different weeks.

The survey included a set of standardized items (41 items) that assess parents'/caretakers' perspectives on their child's care. The survey questions were categorized into eight measures of experience that included four global ratings and four composite measures. The global ratings reflected parents'/caretakers' overall experience with their child's personal doctor, specialist, overall healthcare, and health plan. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). HSAG aggregated data from survey respondents into a database for analysis. For any case where a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

For each of the four global ratings, the percentage of respondents who chose the top ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the CAHPS survey were "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for the composite measures was defined as a response of "Usually" or "Always."

How Data Were Aggregated and Analyzed

HSAG stratified the results by the four CHP+ health plans. HSAG followed NCQA methodology when calculating the results.

HSAG performed a trend analysis of the results in which the FY 2022–2023 scores were compared to their corresponding FY 2021–2022 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2022–2023 top-box scores and the FY 2021–2022 top-box scores are noted with directional triangles. A CHP+ health plan's score that was statistically significantly higher in FY 2022–2023 than FY 2021–2022 is noted with a green upward (▲) triangle. A CHP+ health plan's score that was statistically significantly lower in FY 2022–2023 than FY 2021–2022 is noted with a red downward (▼) triangle. A CHP+ health plan's score that was not statistically significantly different between years is not noted with a triangle.

Also, HSAG performed comparisons of the results to the NCQA national averages. Statistically significant differences between the CHP+ health plans' top-box scores and the NCQA national averages are noted with arrows. A CHP+ health plan's top-box score that was statistically significantly higher than the NCQA national average is noted with a green upward (↑) arrow. A CHP+ health plan's top-box score that was statistically significantly lower than the NCQA national average is noted with a red downward (↓) arrow. A CHP+ health plan's top-box score that was not statistically significantly different than the NCQA national average is not denoted with an arrow.

In addition, HSAG performed health plan comparisons of the results. Given that differences in case-mix can result in differences in ratings between health plans that are not due to differences in quality, the data for the health plans were case-mix adjusted for survey-reported member general health status, member mental or emotional health status, respondent education level, and respondent age to account for disparities in these characteristics; therefore, the health plan comparison results of the four CHP+ health plans may be different than the trend analysis results. Statistically significant differences between the CHP+ health plans' and the statewide aggregate top-box scores are noted with arrows. A CHP+ health plan's top-box score that was statistically significantly higher than the statewide aggregate score is noted with a black upward (↑) arrow. A CHP+ health plan's top-box score that was statistically significantly lower than the statewide aggregate score is noted with a black downward (↓) arrow. A CHP+ health plan's top-box score that was not statistically significantly different than the statewide aggregate score is not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the CHP+ health plans, HSAG determined that each of the measures was related to one or more of the three domains of care (quality, timeliness, or access). This relationship between the measures and the domains of care is depicted in Table 2-9.

Table 2-9—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

CAHPS Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

EQR Dashboard

Objectives

The EQR Dashboard was designed to allow the Department to monitor and track the MCEs' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, and PIPs.

Technical Methods of Data Collection

Data were gathered for performance measures, CAHPS, compliance audits, and PIPs as detailed in their respective sections of this EQR technical report.

Description of Data Obtained

HSAG obtained the results needed to populate the dashboard from other EQR activities including performance measures, CAHPS, compliance audits, and PIPs.

How Data Were Aggregated and Analyzed

Performance measures and CAHPS results were evaluated together to form an overall summary score. This information was displayed along with compliance scores and PIPs to allow users to assess health plan performance across a number of different EQR activities at a glance.

HSAG developed the following dashboard:

- **Compare Health Plans Overall, by Domain, and by Measure**—This view allows the user to select a program and review how all health plans with the program are performing at a high level. This view also provides results for CAHPS, performance measures, compliance, and PIPs.

This dashboard allows the user to assess health plan performance on performance measures and/or CAHPS at different levels of aggregation (domain, measure, indicator) to facilitate identification of high and lower performers.

How Conclusions Were Drawn

Users may use the filtered results to determine how an individual health plan within a program performed based on the health plan's Core Set and CAHPS data.

- The *CAHPS Performance by Plan* table represents the health plans' overall performance on CAHPS measures, with five stars indicating a highest performing health plan and one star indicating a lowest performing health plan. Star ratings are available based on a health plan's performance compared to the statewide average and in relation to NCQA Quality Compass national benchmarks.
- The *Compliance* table provides the overall number of metrics where the statewide standard is met. Additional detail on the specific measure results can be found via the tooltip or by selecting the *Standards* table and the applicable year from the table.
- The *PIP* results are summarized by module to include the PIP topic, SMART Aim statement, follow-up, status of each module, and confidence level.

QOC Grievances and Concerns Audit

Objectives

In an effort to understand the QOC grievance and concern activity for the five MCEs, and to design a robust monitoring mechanism, the Department requested that HSAG develop an audit designed to gather information regarding the processes for addressing QOC grievances and concerns. This project was designed as a focus study with the goal of providing information to the Department for use in improving monitoring efforts and ultimately resulting in improving the health outcomes of Colorado's CHP+ populations.

Technical Methods of Data Collection

HSAG collected data through a document review, QOC grievance and/or concern case review sample, and teleconference interviews.

Description of Data Obtained

Policies, procedures, desktop protocols, process documents, and member and provider informational materials regarding QOC grievances and concerns were obtained from the MCEs. In addition, HSAG requested that each MCE submit a complete list of all QOC grievances and concerns that warranted investigation during the review period, whether the final outcome was substantiated or not. HSAG selected a sample of up to 10 cases for review for each MCE. If the MCE had 10 or less cases within the review period, HSAG requested review materials for each case. The MCEs then submitted to HSAG all

review materials for each case, which included documentation of investigation of the QOC grievance or concern and resolution/outcome documents.

How Data Were Aggregated and Analyzed

HSAG aggregated the results of the document review, record review, and teleconference interviews to develop individualized findings and an overall summary of findings regarding the MCEs' processes for addressing QOC grievances and concerns.

How Conclusions Were Drawn

The sample of potential QOC grievance and concern cases were assessed for compliance with the MCE's own policies and procedures and any MCE contract requirements applicable during the review period.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2022–2023. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality, timeliness, or accessibility of care and services for each MCE independently as well as related to statewide improvement. The interactive functionality of the EQR Dashboard provides the Department with insight into all three domains of care (quality, timeliness, and access).

3. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Table 3-1 shows the FY 2022–2023 statewide PIP results for the CHP+ health plans.

Table 3-1—FY 2022–2023 Statewide PIP Results for the CHP+ Health Plans

Health Plan	PIP Topic	Module Status	Validation Status
COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
Kaiser	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*
DentaQuest	*Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*	Completed Module 1, Module 2, Module 3, and Module 4	*High Confidence*

Statewide Conclusions and Recommendations Related to Validation of PIPs

During FY 2022–2023, the MCEs continued ongoing PIPs. The CHP+ MCOs continued PIPs focused on *Depression Screening and Follow-Up After a Positive Depression Screen*, and the PAHP continued a PIP focused on the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*. The MCEs completed Module 4—PIP Conclusions, the final module of the rapid-cycle PIP process, during FY 2022–2023. In Module 4, the MCEs reported final PIP results, conclusions, and lessons learned. HSAG reviewed and conducted the final validation on the Module 4 submissions and assigned an overall validation status to each PIP. All CHP+ MCOs and the PAHP received a validation rating of *High Confidence*, based on the validation findings.

Based on the FY 2022–2023 PIP validation activities, HSAG identified the following statewide strengths:

- The MCEs developed and carried out methodologically sound improvement projects.
- The MCEs accurately reported SMART Aim measure and intervention testing results.
- The MCEs' reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance and/or met the SMART Aim goals.
- The MCEs' intervention testing results demonstrated programmatically significant improvement and/or clinically significant improvement linked to the tested interventions.

Based on the FY 2022–2023 PIP validation activities, HSAG did not identify any statewide opportunities for improvement.

As the MCEs complete the current PIPs, HSAG recommends:

- The MCEs apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- The MCEs continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Validation of Performance Measures

Statewide Results

Information Systems Standards Review

HSAG reviewed each MCE's FAR. Each MCE's LO's auditor evaluated the MCEs' IS standards and determined the MCEs to be fully compliant with all IS standards, relevant to the scope of the PMV performed. During review of the IS standards, the auditors identified no notable issues with negative impact on performance measure reporting.

Performance Measure Results

Table 3-2 presents the MCO-specific and statewide weighted averages for the CHP+ MCOs for HEDIS MY 2022. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the MCOs' eligible populations. For the MCOs with rates reported as *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate.

Table 3-2—MCO and Statewide Results for HEDIS MY 2022

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Primary Care Access and Preventive Care					
Child and Adolescent Well-Care Visits					
Total	41.86%	43.71%	42.70%	47.14%	42.88%
Childhood Immunization Status					
Combination 3	57.93%	78.95%	67.71%	64.38%	61.19%
Combination 7	52.58%	68.42%	60.42%	61.64%	55.84%
Combination 10	37.64%	52.63%	47.92%	37.67%	39.54%
Chlamydia Screening in Women					
Ages 16 to 20 Years	29.07%	42.31%	38.61%	32.12%	31.44%
Developmental Screening in the First Three Years of Life					
Total	33.36%	55.12%	61.54%	58.87%	37.84%
Immunizations for Adolescents					
Combination 1 (Meningococcal; Tetanus, Diphtheria, and Pertussis [Tdap])	71.79%	82.73%	79.58%	61.33%	71.47%
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	33.31%	46.76%	43.31%	22.43%	33.30%
Lead Screening in Children					
Lead Screening in Children	30.88%	61.54%	2.08%	35.37%	29.78%

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	17.90%	64.65%	90.56%	20.36%	28.21%
Counseling for Nutrition—Total	18.71%	69.97%	91.40%	24.06%	29.71%
Counseling for Physical Activity—Total	13.20%	69.13%	91.75%	18.52%	25.03%
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	52.51%	NA	23.61%	41.18%	46.06%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	55.06%	63.89%	64.20%	70.00%	59.14%
Maternal and Perinatal Health					
Contraceptive Care—All Women					
Most or Moderately Effective Contraception (MMEC)—Ages 15 to 20 Years	16.44%	9.32%	17.62%	20.88%	16.87%
Long-Acting Reversible Contraception (LARC)—Ages 15 to 20 Years	2.86%	1.43%	4.13%	4.52%	3.19%
Contraceptive Care—Postpartum Women					
MMEC—3 Days—Ages 15 to 20 Years	NA	NA	NA	NA	0.00%
MMEC—90 Days—Ages 15 to 20 Years	NA	NA	NA	NA	64.86%
LARC—3 Days—Ages 15 to 20 Years	NA	NA	NA	NA	2.70%
LARC—90 Days—Ages 15 to 20 Years	NA	NA	NA	NA	35.14%
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	34.07%	75.00%	70.21%	38.10%	42.05%
Care of Acute and Chronic Conditions					
Asthma Medication Ratio					
Total (Ages 5 to 18 Years)	58.29%	NA	80.00%	77.78%	61.64%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	81.48%	NA	NA	81.16%	82.81%
Behavioral Health Care					
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—Ages 13 to 17 Years	22.58%	NA	NA	NA	26.83%
30-Day Follow-Up—Ages 13 to 17 Years	29.03%	NA	NA	NA	31.71%
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Ages 6 to 17 Years	76.27%	NA	NA	NA	58.54%
30-Day Follow-Up—Ages 6 to 17 Years	86.44%	NA	NA	NA	71.95%

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Ages 6 to 17 Years	30.08%	NA	NA	NA	40.36%
30-Day Follow-Up—Ages 6 to 17 Years	72.36%	NA	NA	NA	75.90%
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	36.62%	NA	54.84%	41.86%	38.64%
Continuation and Maintenance Phase	52.83%	NA	NA	NA	53.33%
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose Testing—Total	47.62%	NA	NA	NA	51.57%
Cholesterol Testing—Total	24.60%	NA	NA	NA	28.30%
Blood Glucose and Cholesterol Testing—Total	23.81%	NA	NA	NA	27.67%
Screening for Depression and Follow-Up Plan					
Ages 12 to 17 Years	14.47%	33.60%	1.00%	9.17%	13.41%
Use of Services					
Ambulatory Care: Emergency Department Visits*					
Total (Ages 0 to 19 Years)	289.07	218.97	228.53	209.36	266.30

**For this indicator, a lower rate indicates better performance.*

— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statewide Strengths

The following statewide HEDIS MY 2022 measure rate was determined to be a high-performing rate (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2021, or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2021) for the CHP+ statewide weighted average:

- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17 Years*

Statewide Conclusions and Recommendations Related to Performance Measures

The following statewide HEDIS MY 2022 measure rates were determined to be low-performing rates (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS MY 2021) for the CHP+ statewide weighted average:

- *Child and Adolescent Well-Care Visits—Total*

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Immunizations for Adolescents—Combination 1* and *Combination 2*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Lead Screening in Children*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

To address these low measure rates, HSAG recommends the MCOs:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends the Department consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The Department should encourage the MCOs to consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-3 presents the overall percentage of compliance score for each MCE for all standards and the year reviewed.

Table 3-3—Statewide Results for CHP+ Managed Care Standards

Description of Standard	COA	DHMP	Kaiser	RMHP	Denta-Quest*	Statewide Average
Standard I—Coverage and Authorization of Services (2019-2020, 2022–2023)	**88%^**	**97%~**	**88%^**	**97%^**	**71%^**	**88%^**
Standard II—Adequate Capacity and Availability of Services (2019-2020, 2022–2023)	**100%~**	**93%^**	**100%~**	**93%v**	**75%^**	**92%^**
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	100%~	100%^	100%^	100%^	40%	90%^
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	100%^	100%~	60%v	100%^	100%	88%v
Standard V—Member Information Requirements (2017–2018, 2020–2021)	95%v	95%^	90%v	95%v	63%	84%v
Standard VI—Grievance and Appeal Systems (2020-2021, 2022–2023)	**90%^**	**77%v**	**71%^**	**94%v**	**58%v**	**78%v**
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	100%~	93%^	100%^	94%^	87%	91%^
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%~	97%v	100%~	100%~	100%	95%v
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	100%	75%	75%	75%	100%	79%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2018–2019, 2021–2022)	94%^	100%^	100%^	100%^	50%	92%^
Standard XII—Enrollment and Disenrollment (2022–2023)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**FY 2019–2020 was the first year of review for DentaQuest.*

Green caret (^) indicates an increase from review three years prior. Red caret (v) indicates a decrease from review three years prior.

~ Indicates no change from prior year.

In FY 2017–2018, all MCEs received a score of "NA" for the Subcontractual Relationships and Delegation standard. All requirements within this standard were new as of the 2016 managed care revisions, yet the MCEs were not required to comply until FY 2018–2019.

Table 3-4 presents the compliance scores for record reviews conducted for each MCE during FY 2022–2023.

Table 3-4—Statewide Results for CHP+ Managed Care Record Reviews

Record Review	COA	DHMP	Kaiser	RMHP	Denta-Quest	Statewide Average
Appeals (2022–2023)	**91%**	**84%**	**100%**	**100%**	**98%**	**95%**
Denials (2022–2023)	**80%**	**84%**	**96%**	**90%**	**85%**	**87%**
Grievances (2022–2023)	**100%**	**NA**	**100%**	**97%**	**100%**	**99%**
Credentialing (2021–2022)	100%	100%	100%	100%	100%	100%
Recredentialing (2021–2022)	100%	100%	100%	100%	96%	99%

Bold text indicates record reviews conducted by HSAG during FY 2022–2023.

Statewide Conclusions and Recommendations Related to Assessment of Compliance

Based on the four standards reviewed in FY 2022–2023, HSAG found the following common strengths among the MCEs:

- All the MCEs met the requirement to conduct utilization management (UM) interrater reliability (IRR) testing to ensure consistent application of review criteria.
- The MCEs continued efforts to communicate with the Department regarding high-need members.
- Network adequacy plans, policies, procedures, and committee meeting minutes described oversight and monitoring of the provider network.
- Most MCEs submitted policies and procedures that outlined how members received reasonable assistance (i.e., help completing forms, offering accommodations, and other services upon request).
- All MCEs demonstrated adequate systems to document grievances and appeals.
- Member communications regarding notices of adverse benefit determination (NABDs), grievances, and appeals were written at or around the sixth-grade reading level.
- Staff members described a thorough overview of how the enrollment process begins when the Electronic Data Interchange (EDI) 834 files are received from the Department and are added to their systems with no restriction.

For the MCEs statewide, HSAG identified the following most common opportunities for improvement:

- Most MCEs' policies, procedures, and member handbooks did not include all federal and state-specific requirements related to coverage and authorization of services.
- Information regarding the Children and Youth Mental Health Treatment Act (CYMHTA) was not included in NABD templates at the time of the audit for two MCEs.
- All MCEs reported gaps in time and distance standards.
- Some MCEs used shortened time frames and did not utilize extensions for authorizations, grievances, and appeals decisions when in the best interest of the member.
- Language in either member letters, policies, procedures, websites, or other supporting documentation often incorrectly stated the member needed to follow up an oral appeal request in writing, which is no longer a federal requirement.
- Continuation of benefits language was often incorrectly included in member notices.

To address the opportunities for improvement, HSAG recommends the following:

- Require the MCEs to conduct occasional quality assurance verification procedures to ensure that NABD templates are aligned with the correct LOB.
- Continue working with the Department to identify ways to improve compliance with time and distance standards.
- When updating access to care standards, the Department may consider requiring the MCEs to promptly revise language related to correct standards for timely access to care related to urgent services in handbooks, policies, or other applicable materials.
- Encourage the MCEs to use extensions for authorization, grievance, and appeal decisions when in the best interest of the member. Some used shortened time frames in which members or providers were allowed to submit additional documentation.
- In response to updates to federal requirements, the Department may consider requiring the MCEs to promptly update supporting documentation (e.g., when appeals were no longer required in writing) and removing continuation of benefits language, which is no longer applicable to CHP+.

Validation of Network Adequacy

Time and Distance Analysis

Statewide Results

Quarterly during FY 2022–2023, HSAG validated the MCEs' self-reported compliance with minimum network requirements and provided the Department with both MCE-specific initial file review results in the NADIV dashboards and final validation results in quarterly NAV dashboards.

The data-related findings in this report align with HSAG's validation of the MCEs' FY 2022–2023 Q2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2022, through December 31, 2022.

For an MCE to be compliant with the FY 2022–2023 minimum network requirements, the MCE is required to ensure that its practitioner network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level) unless otherwise specified (i.e., 90 percent access level). For example, all members residing in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two family practitioners. However, if members reside in counties outside their MCE's contracted geographic area, the Department does not necessarily require the MCE to meet the minimum network requirements for those members. Additionally, the MCEs may have alternate methods of ensuring access to care for its enrolled members, regardless of a member's county of residence (e.g., the use of telehealth).

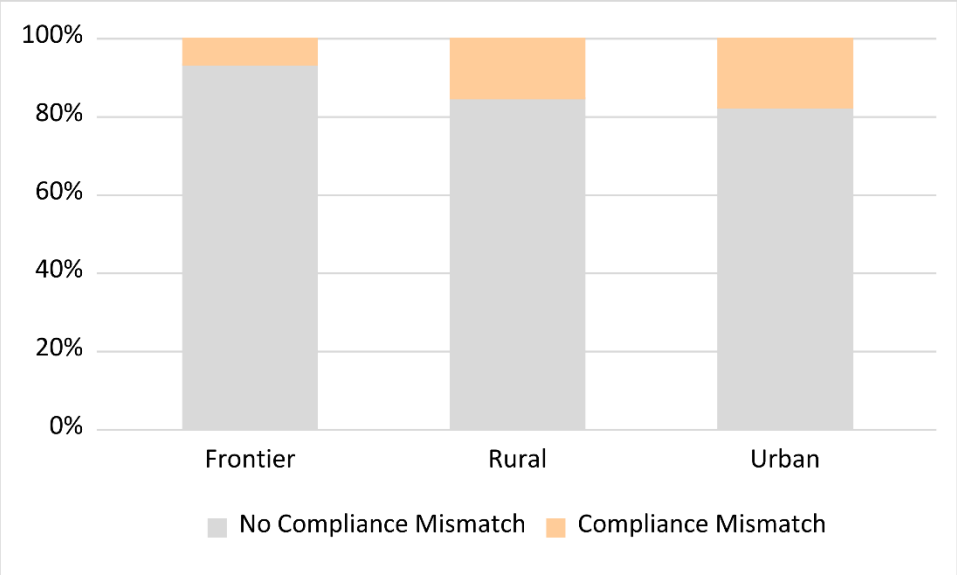
CHP+ MCO Results

This section summarizes the FY 2022–2023 NAV findings specific to the four CHP+ MCOs.

Compliance Match

Figure 3-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the CHP+ MCOs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the CHP+ MCOs' quarterly geoaccess compliance results) among all CHP+ MCOs by urbanicity.

Figure 3-1—Aggregate CHP+ MCO Geoaccess Compliance Validation Results for FY 2022–2023 by Urbanicity

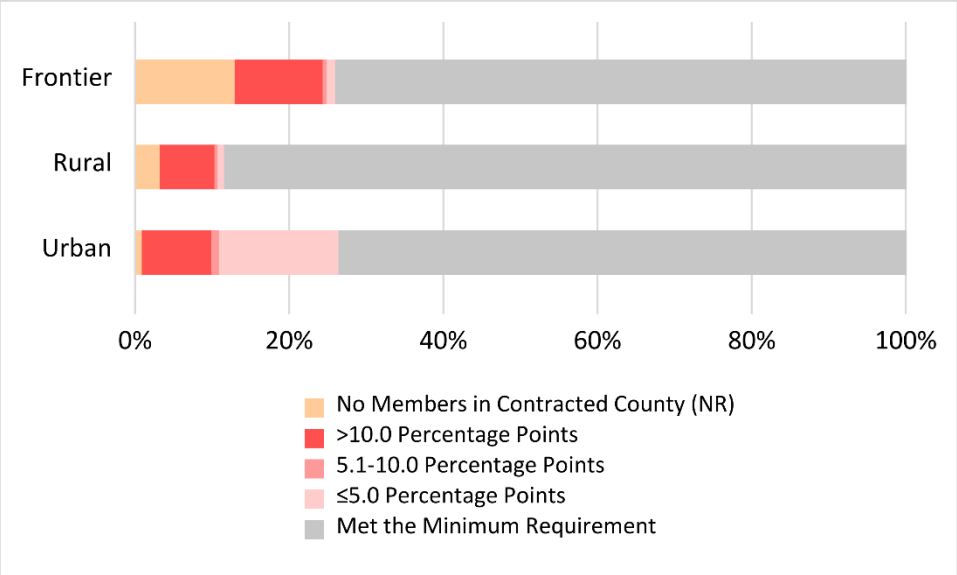


As shown in Figure 3-1, HSAG agreed with 93.4 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 84.8 percent of reported results for rural counties, and 82.4 percent of reported results for urban counties. HSAG disagreed with 6.6 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 15.2 percent of reported results for rural counties, and 17.6 percent of reported results for urban counties.

Access Level Assessment

Figure 3-2 displays the percentage of PH primary care results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2022–2023 Q2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance PH primary care network requirements for the selected counties.

Figure 3-2—Percentage of Aggregate CHP+ MCO PH Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



Minimum time and distance PH primary care requirements include pediatric, adult, and family PCPs, as well as practitioners specializing in OB/GYN. CHP+ MCOs are required to ensure that all members have two PCPs from each specified network type available within the specified network requirements. For example, the CHP+ MCO should contract with two or more pediatric PCPs (i.e., practitioners licensed as MDs, DOs, NPs, or CNSs) located within 30 minutes or 30 miles of each member residing in an urban county. Since the CHP+ MCOs are contracted to cover different Colorado counties each combination of a minimum time and distance requirement and county is measured separately.

Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 3-2 summarizes the number of PH primary care results (i.e., minimum network time and distance requirement and county combinations) in which all members had access within the minimum network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

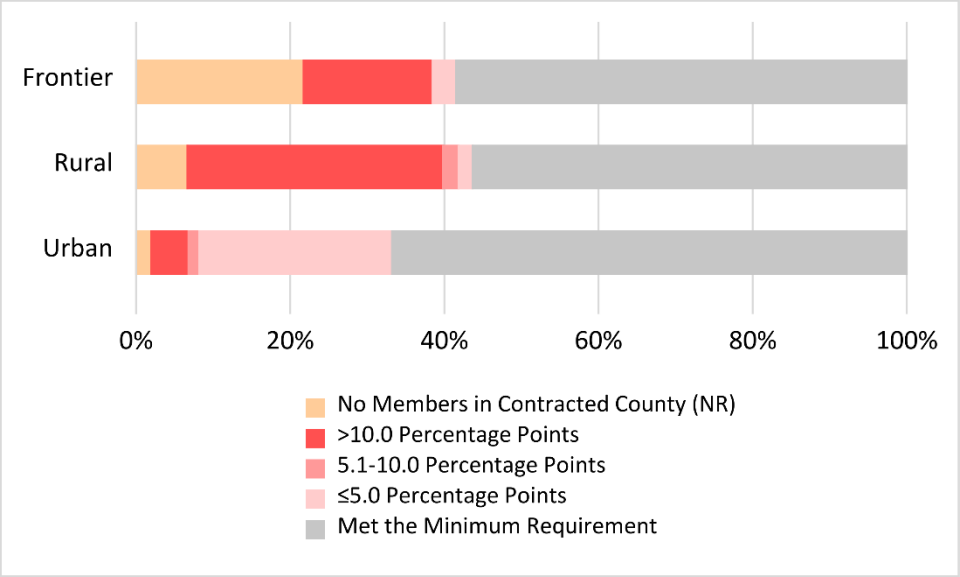
- The top bar in Figure 3-2 reflects a total of 184 PH primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 184 CHP+ MCO frontier results, 73.9 percent (n=136) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 1.1 percent (n=2) of the frontier county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 0.5 percent (n=1) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 11.4 percent (n=21) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, due to the limited number of adult CHP+ MCO

members, 13.0 percent (n=24) of the results have no CHP+ MCO members within the appropriate age range for the PH primary care requirements residing in the contracted frontier counties.

- The middle bar in Figure 3-2 reflects a total of 240 PH primary care results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 240 CHP+ MCO rural results, 88.3 percent (n=212) have 100 percent of CHP+ MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 0.8 percent (n=2) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 0.4 percent (n=1) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 7.1 percent (n=17) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 3.3 percent (n=8) of the results have no CHP+ MCO members within the appropriate age range for the PH primary care network requirements residing in the contracted rural counties.
- The bottom bar in Figure 3-2 reflects a total of 200 PH primary care results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 200 CHP+ MCO urban results, 73.5 percent (n=147) have 100 percent of CHP+ MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 15.5 percent (n=31) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 1.0 percent (n=2) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 9.0 percent (n=18) of the urban county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 1.0 percent (n=2) of the results have no CHP+ MCO members within the appropriate age range for the PH primary care requirements residing in the contracted urban counties.

Figure 3-3 displays the percentage of PH specialist network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with access within the minimum network requirement by urbanicity for FY 2022–2023 Q2. 'NR' indicates that no CHP+ MCO members had access within the criteria for the primary care network requirements for the selected counties.[3-1]

Figure 3-3—Percentage of Aggregate CHP+ MCO PH Specialist Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



Minimum time and distance PH specialist requirements include practitioners such as cardiologists, endocrinologists, and gastroenterologists, etc. CHP+ MCOs are required to ensure that all members have two PH specialist practitioners from each specified network type available within the specified minimum network requirement. For example, the CHP+ MCO should contract with two or more pediatric cardiologists located within 30 minutes or 30 miles of each member residing in an urban county. Since the CHP+ MCOs are contracted to cover different Colorado counties, each combination of a minimum network requirement and county is measured separately.

Two or more practitioners in a given network category may not be located within the CHP+ MCOs' minimum network requirements for all members. As such, Figure 3-3 summarizes the number of PH specialist results (i.e., minimum network requirement and county combinations) in which all members had access within the minimum network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 3-3 reflects a total of 460 PH specialist results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each

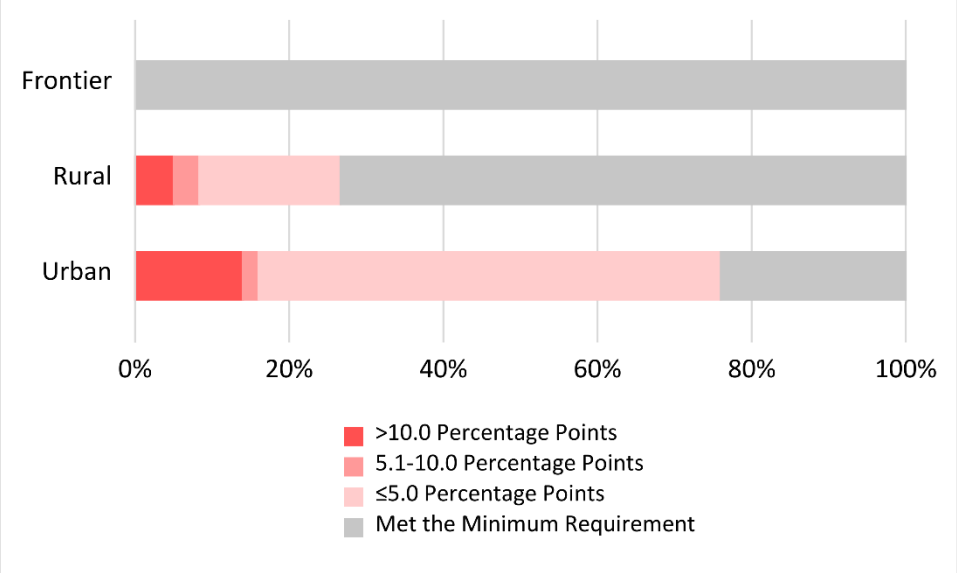
[3-1] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 460 CHP+ MCO frontier results, 58.5 percent (n=269) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 3.0 percent (n=14) of the frontier county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level). Additionally, 16.7 percent (n=77) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, due to the limited number of adult CHP+ MCO members, 21.7 percent (n=100) of the results have no CHP+ MCO members within the appropriate age range for the PH specialist requirements residing in the contracted frontier counties.

- The middle bar in Figure 3-3 reflects a total of 600 PH specialist results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 600 CHP+ MCO rural results, 56.3 percent (n=338) have 100 percent of CHP+ MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 1.8 percent (n=11) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 2.0 percent (n=12) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 33.2 percent (n=199) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 6.7 percent (n=40) of the results have no CHP+ MCO members within the appropriate age range for the PH specialist requirements residing in the contracted rural counties.
- The bottom bar in Figure 3-3 reflects a total of 500 PH specialist results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 500 CHP+ MCO urban results, 66.8 percent (n=334) have 100 percent of CHP+ MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 25.0 percent (n=125) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 1.4 percent (n=7) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 4.8 percent (n=24) of the urban county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 2.0 percent (n=10) of the results have no CHP+ MCO members within the appropriate age range for the PH specialist requirements residing in the contracted urban counties.

Figure 3-4 displays the percentage of PH entity network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with residential addresses within the minimum network requirements by urbanicity for FY 2022–2023 Q2. 'NR' indicates that no CHP+ MCO members had access within the criteria for the primary care network requirements for the selected counties.[3-2]

Figure 3-4—Percentage of Aggregate CHP+ MCO PH Entity Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



Minimum time and distance PH entity requirements include acute care hospitals and pharmacies. CHP+ MCOs are required to ensure that all members have two PH entities from each specified network type available within the specified time and distance requirement. For example, the CHP+ MCO should contract with two or more pharmacies located within 10 minutes or 10 miles of each member residing in an urban county. Since the CHP+ MCOs are contracted to cover different Colorado counties, each combination of a minimum network requirement and county is measured separately.

Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 3-4 summarizes the number of PH entity results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 3-4 reflects a total of 46 PH entity results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 46 CHP+ MCO frontier results, 100 percent (n=46) have 100 percent of CHP+ MCO members

[3-2] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

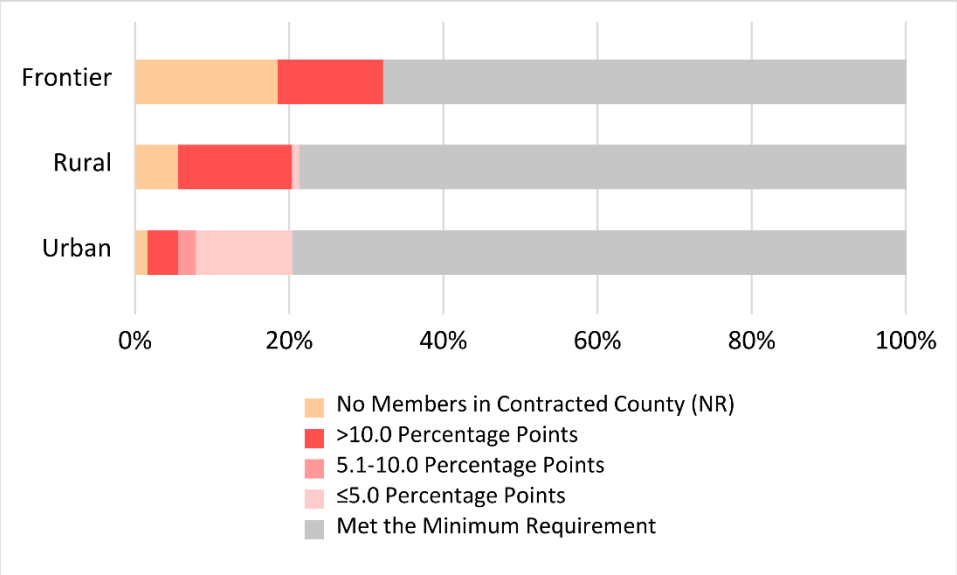
with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level).

- The middle bar in Figure 3-4 reflects a total of 60 PH entity results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 60 CHP+ MCO rural results, 73.3 percent (n=44) have 100 percent of CHP+ MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 18.3 percent (n=11) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 3.3 percent (n=2) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 5.0 percent (n=3) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The bottom bar in Figure 3-4 reflects a total of 50 PH entity results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 50 CHP+ MCO urban results, 24.0 percent (n=12) have 100 percent of CHP+ MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 60.0 percent (n=30) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 2.0 percent (n=1) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 14.0 percent (n=7) of the urban county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

Figure 3-5 displays the percentage of BH results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2022–2023 Q2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the BH requirements for the selected counties.[3-3]

[3-3] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

Figure 3-5—Percentage of Aggregate CHP+ MCO BH Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



Minimum time and distance BH requirements include pediatric and adult psychiatrists and other psychiatric prescribers and SUD treatment practitioners and entities, as well as psychiatric hospitals or psychiatric units in acute care hospitals. CHP+ MCOs are required to ensure that all members have two BH practitioners or practice sites from each specified network type available within the specified time and distance requirement. For example, the CHP+ MCO should contract with two or more pediatric psychiatrists or other psychiatric prescribers located within 30 minutes or 30 miles of each member residing in an urban county. Since the CHP+ MCOs are contracted to cover different Colorado counties each combination of a minimum network requirement and county is measured separately.

Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 3-5 summarizes the number of BH results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 3-5 reflects a total of 161 BH results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 161 CHP+ MCO frontier results, 67.7 percent (n=109) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional, 13.7 percent (n=22) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, due to the limited number of adult CHP+ MCO members, 18.6 percent (n=30) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted frontier counties.

- The middle bar in Figure 3-5 reflects a total of 210 BH results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 210 CHP+ MCO rural results, 78.6 percent (n=165) have 100 percent of CHP+ MCO members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 1.0 percent (n=2) of the rural county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 14.8 percent (n=31) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 5.7 percent (n=12) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted rural counties.
- The bottom bar in Figure 3-5 reflects a total of 175 BH results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 175 CHP+ MCO urban results, 79.4 percent (n=139) have 100 percent of CHP+ MCO members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 12.6 percent (n=22) of the urban county results were less than or equal to 5.0 percentage points of meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 2.3 percent (n=4) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). Additionally, 4.0 percent (n=7) of the urban county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level). As expected, 1.7 percent (n=3) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted urban counties.

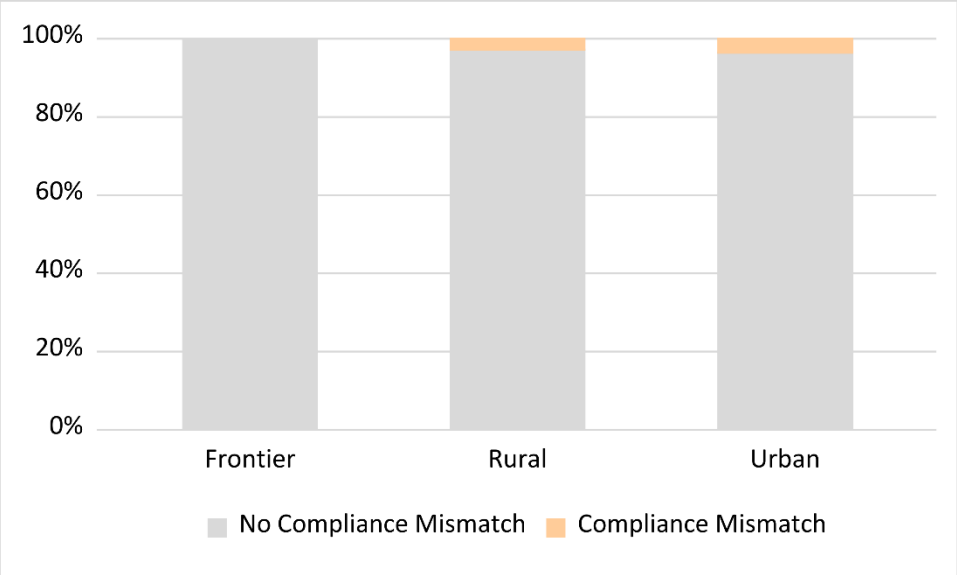
PAHP Results

This section summarizes the FY 2022–2023 NAV findings specific to the PAHP.

Compliance Match

Figure 3-6 displays the rate of compliance mismatch (i.e., HSAG did not agree with the PAHP's quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the PAHP's quarterly geoaccess compliance results) by urbanicity.

Figure 3-6—Aggregate PAHP Geoaccess Compliance Validation Results for FY 2022–2023 Q2 by Urbanicity

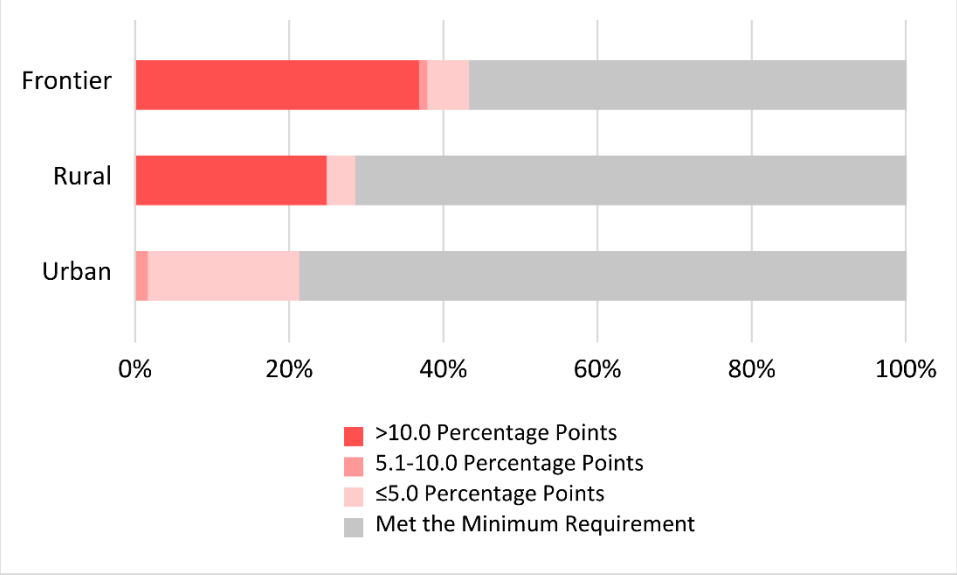


As shown in Figure 3-6, HSAG agreed with 100 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 97.2 percent of reported results for rural counties, and 96.4 percent of reported results for urban counties. HSAG disagreed with 2.8 percent of the PAHP's reported quarterly geoaccess compliance results for rural counties and 3.6 percent of reported results for urban counties.

Access Level Assessment

Figure 3-7 displays the percentage of minimum time and distance dental network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of PAHP members with access within the network requirement by urbanicity for FY 2022–2023 Q2.

Figure 3-7—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2022



Minimum time and distance dental requirements pertain to general and pediatric dentists, as well as practitioners specializing as oral surgeons or orthodontists. The PAHP is required to ensure that all members have one dental practitioner from each specified network type available within the specified time and distance requirement. For example, the PAHP should contract with one adult dentist located within 30 minutes or 30 miles of each member residing in an urban county. Since contract requirements vary by urbanicity, and the PAHP is contracted to cover all Colorado counties each combination of a time and distance network requirement and county is measured separately.

Not all members may reside within the PAHP's contractual minimum network requirements for one practitioner in a given network category. As such, Figure 3-7 summarizes the number of dental results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The first bar in Figure 3-7 reflects a total of 92 dental results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the PAHP is contracted to serve. Of those 92 PAHP frontier results, 56.5 percent (n=52) have 100 percent of PAHP members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 5.4 percent (n=5) of the frontier county results were less than or equal to 5.0 percentage points within meeting the minimum network requirements (i.e., 95 to 99.9 percent access level) and 1.1 percent (n=1) of the frontier county results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level). In addition, 37.0 percent (n=34) of the frontier county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).

- The second bar in Figure 3-7 reflects a total of 108 dental results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the PAHP is contracted to serve. Of those 108 PAHP rural results, 71.3 percent (n=77) have 100 percent of PAHP members with residential addresses in rural counties that had access within the minimum network requirements (i.e., 100 percent access level), 3.7 percent (n=4) of the rural county results were less than or equal to 5.0 percentage points within meeting the minimum network requirements (i.e., 95 to 99.9 percent access level), and 25.0 percent (n=27) of the rural county results were greater than 10.0 percentage points away from the minimum time and distance requirements (i.e., less than or equal to 89.9 percent access level).
- The third bar in Figure 3-7 reflects a total of 56 dental results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the PAHP is contracted to serve. Of those 56 PAHP urban results, 78.6 percent (n=44) have 100 percent of PAHP members with residential addresses in urban counties that had access within the minimum network requirements (i.e., 100 percent access level), 19.6 percent (n=11) of the urban county results were less than or equal to 5.0 percentage points within meeting the minimum network requirements (i.e., 95 to 99.9 percent access level), and 1.8 percent (n=1) of the results were within 5.1 to 10.0 percentage points of the minimum network requirements (i.e., 94.9 to 90 percent access level).

Provider Directory Validation

Statewide Results

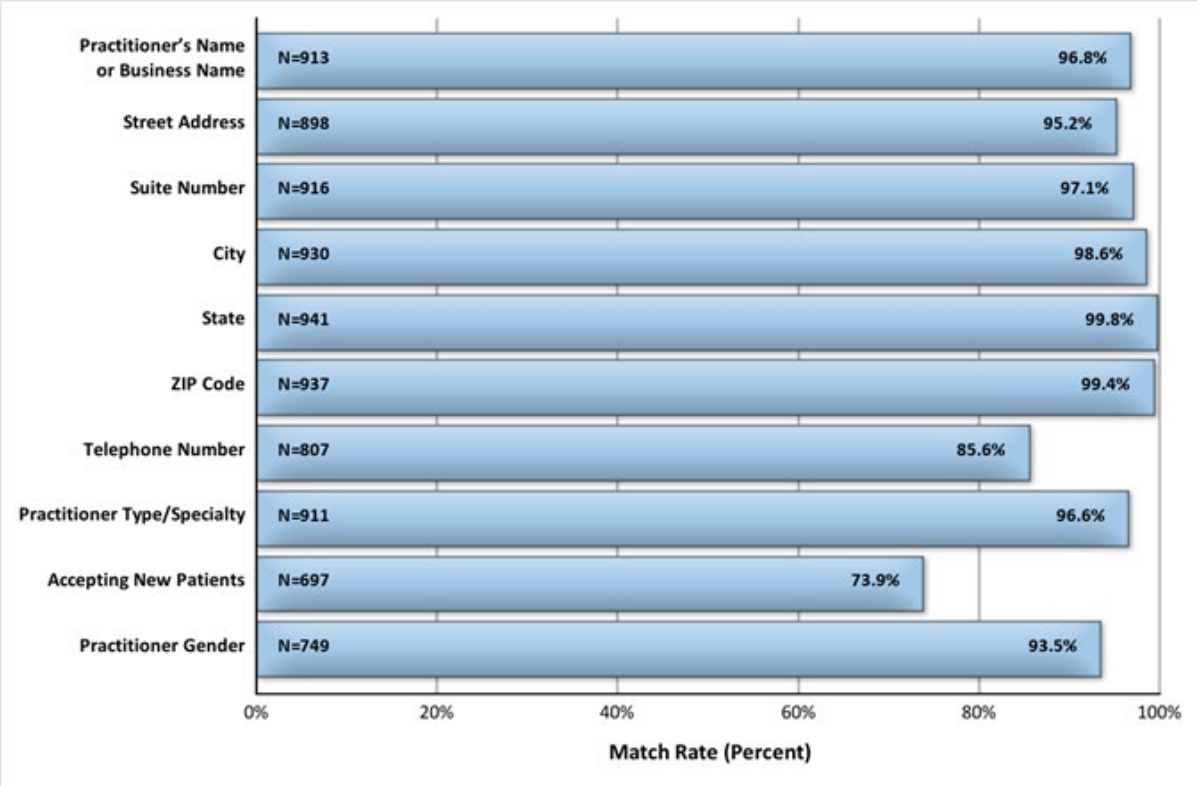
Table 3-5 summarizes the number of sampled providers and provider locations (i.e., "cases") that were located in the MCEs' online provider directories.

Table 3-5—Summary of Sampled Providers Located in Online Provider Directories

MCE	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	%	Count	%	Count	%
CHP+ MCOs							
COA	411	174	42.3%	58	14.1%	179	43.6%
DHMP	411	280	68.1%	42	10.2%	89	21.7%
Kaiser	411	36	8.8%	12	2.9%	363	88.3%
RMHP	411	81	19.7%	18	4.4%	312	75.9%
CHP+ MCO Total	**1,644**	**571**	**34.7%**	**130**	**7.9%**	**943**	**57.4%**
PAHP							
DentaQuest	411	16	3.9%	3	0.7%	392	95.4%
PAHP Total	**411**	**16**	**3.9%**	**3**	**0.7%**	**392**	**95.4%**

Figure 3-8 displays the percentage of sampled provider locations found in the online provider directories that matched between the CHP+ MCOs' provider data files and the online provider directory information for all study indicators.

Figure 3-8—CHP+ MCO Aggregate: PDV Findings[3-4,3-5]

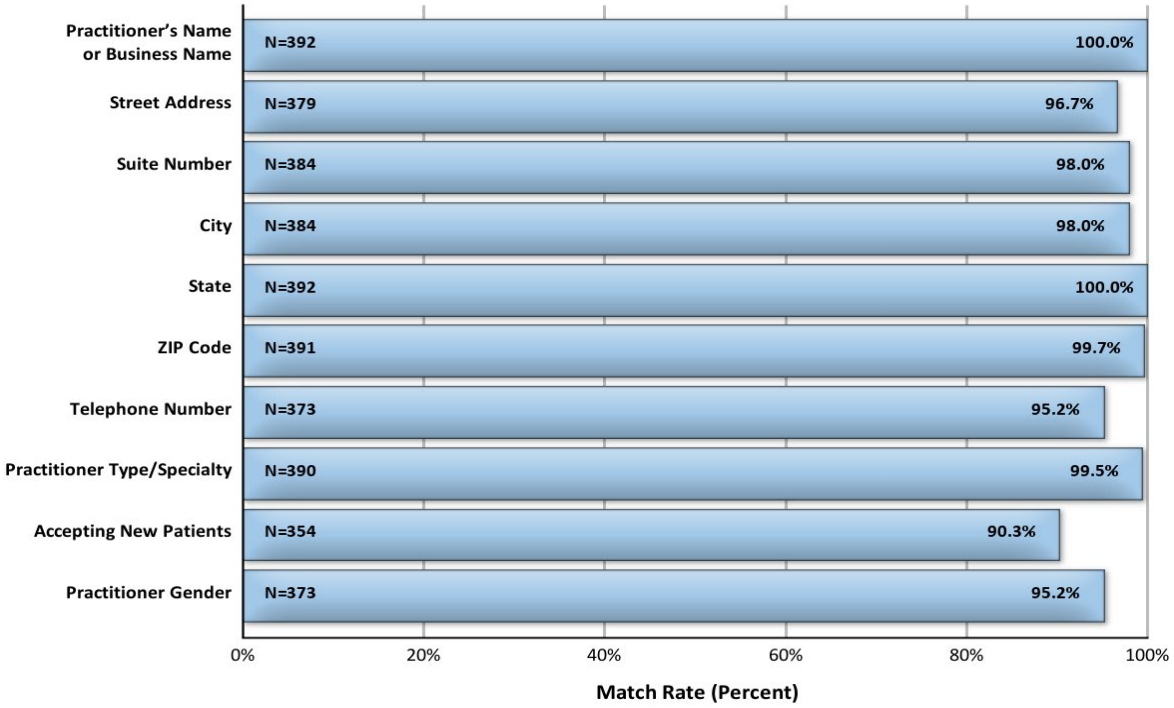


3-4 Indicators missing in the online provider directory may have contributed to low match rates.

3-5 The "Practitioner Gender" indicator was not assessed for facilities.

Figure 3-9 displays the percentage of sampled provider locations found in the online provider directories that matched between the PAHP's provider data files and the online provider directory information for all study indicators.

Figure 3-9—PAHP: PDV Findings[3-6,3-7]



Analytic Considerations

Various factors associated with the SFY 2023 PDV may have affected the validity or interpretation of the results when generalizing directory review findings to the MCEs' provider data, including, but not limited to, the following analytic considerations:

- HSAG received the provider data from the MCEs in October 2022 and completed the directory reviews from November 21, 2022, through December 22, 2022. In this time period, it is possible that the provider data submitted by the MCEs could have changed and subsequently been updated in the online provider directories. This limitation would most likely affect the ability to locate the provider in the online directory and exact-match rates for indicators with the potential for short-term changes (e.g., the provider's address, telephone number, or new patient acceptance status). For example, it is possible that a provider was accepting new patients when the MCE submitted the provider data to HSAG but was no longer accepting new patients when HSAG compared the data to the MCE's online directory. This would result in a lower exact-match rate for this indicator.

3-6 Indicators missing in the online provider directory may have contributed to low match rates.

3-7 The "Practitioner Gender" indicator was not assessed for facilities.

- The directory reviews involved a comparison of the data submitted by the MCEs against the information in each MCE's online provider directory.
  - Although provider data may match between both sources for a PDV case, it was beyond the scope of study to evaluate the accuracy of the MCEs' provider data against an external standard (e.g., using telephone survey calls to verify the accuracy of telephone numbers). For example, the address for a provider might match between both sources, but the provider may no longer practice at the specified location.
  - Non-matched provider data do not necessarily indicate that the MCE's online provider directory data are inaccurate. The low number of cases with matching new patient acceptance offers an example, as the provider data submitted to HSAG could not be confirmed since the field was not present (i.e., missing) in some online directories.
- HSAG's reviewers conducted the directory reviews using desktop computers with high-speed internet connections. Reviewers did not attempt to access or navigate the MCEs' online provider directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight).

Statewide Conclusions and Recommendations Related to Network Adequacy

Table 3-6 displays the rate of compliance matches (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results), by MCE type and urbanicity. For example, HSAG agreed with 93.4 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, and HSAG agreed with 100 percent of the PAHP quarterly compliance results for frontier counties.

Table 3-6—Aggregate Percentage of Geoaccess Compliance Matches for FY 2022–2023 Q2 by MCE Type and Urbanicity

MCE Type	Percentage of Matching Geoaccess Compliance Results in Frontier Counties	Percentage of Matching Geoaccess Compliance Results in Rural Counties	Percentage of Matching Geoaccess Compliance Results in Urban Counties
CHP+ MCO	93.4%	84.8%	82.4%
PAHP	100%	97.2%	96.4%

Based on FY 2022–2023 time and distance and PDV activities, HSAG identified the following strengths:

- The Department built upon the significant growth in its oversight of the MCEs' networks in the prior fiscal year through the use of standardized quarterly reporting materials and implemented standard changes in select BH network categories.

- The CHP+ MCOs exhibited improvements in member access from the previous fiscal year. Across MCE types, urbanicities, and practitioner network categories, there were notable improvements in the percentage of network requirements assessed for which the MCEs were meeting the Department's 100 percent standard, particularly in the PH primary care provider categories. For example, the CHP+ MCOs demonstrated a 24-percentage-point improvement in meeting the PH primary care requirements in frontier counties, from 49.7 percent to 73.9 percent. The CHP+ MCOs also exhibited more than a 12-percentage-point improvement in rural counties, from 66.7 percent to 88.3 percent, and a 9-percentage-point improvement in urban counties, from 64.5 percent to 73.5 percent.
- In the PH specialist provider category, the CHP+ MCOs also exhibited marked increases in the percentage of network requirements with 100 percent of members meeting the standards. Among the CHP+ MCOs, the increase in requirements meeting the 100 percent standard was 7.4 percent in urban counties, from 59.4 percent to 66.8 percent; 10.9 percent in rural counties, from 45.4 percent to 56.3 percent; and 16.5 percent in frontier counties, from 42.0 percent to 58.5 percent.
- In the BH provider category, the CHP+ MCOs demonstrated notable gains in the percentage of network requirements for which all members were within the time and distance standards. Among the CHP+ MCOs, the percentage point increase in requirements completely meeting minimum network requirements (i.e., 100 percent compliance, or 90 percent compliance where specified for select BH provider categories) was 17.9 percent for frontier counties, from 49.8 percent to 67.7 percent. In rural and urban counties, the increases were 14.1 percentage points, from 64.5 percent to 78.6 percent, and 17.6 percentage points, from 61.8 percent to 79.4 percent, respectively.
- In the dental services provider category, the PAHP exhibited improvements in members' access over the same activity performed in FY 2021–2022. For urban counties, the percentage of requirements with 100 percent access increased from 71.4 percent to 78.6 percent, which is 7.2 percentage points higher than the result in FY 2021–2022. In frontier counties, the percentage of requirements with 100 percent access increased 1.1 percentage points from 55.4 percent to 56.5 percent, while in rural counties, the percentage of requirements with 100 percent access increased 0.8 percentage points from 70.4 percent to 71.3 percent.
- Overall, 95.4 percent of the PAHP providers were located in the online provider directory at the sampled location.
- Once located in the directory, CHP+ MCO providers had match rates above 90 percent for eight of the 10 indicators, and PAHP providers had match rates above 90 percent for all 10 indicators.

Based on the FY 2022–2023 time and distance and PDV activities, HSAG identified the following opportunities for improvement:

- To further assess network adequacy, the Department should consider integrating specified data review topics into network adequacy analysis and an expansion of the NAV dashboard to reflect specific initiatives and goals.

- Only 57.4 percent of the CHP+ MCO providers were located in the online provider directory at the sampled location.
- The telephone number and new patient acceptance indicators had match rates below 90 percent for the CHP+ MCO providers.
- Based on the PDV results, opportunities for improvement were not identified for the PAHP providers.

To address these opportunities for improvement, HSAG identified the following promising practices and recommendations:

- The Department may consider the extent to which the MCEs offer alternate service delivery mechanisms to ensure members' access to care when minimum network requirements may not be the most appropriate method of measuring access for certain geographic areas and/or network provider categories.
- The Department may consider continuing the development and implementation of formal network exception policy and request templates to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards.
- The Department may consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population needs. Although current network standards developed by the Department were designed to assess the number of specific provider types located within given driving times and distances from members, the adequacy of the networks to address specific population needs may be more comprehensively assessed by including and cross-referencing encounter data to assess actual utilization patterns.
- Since the MCEs supplied HSAG with the provider data used for the directory reviews, the Department may want to consider supplying each MCE with case-level data files containing mismatched information between the MCE's data and the MCE's online provider directory and require the MCEs to address these deficiencies.
- The MCEs should test their internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, each MCE should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent and the discrepancy in providers listed in the MCEs' data that could not be located in the online provider directory.

CAHPS Surveys

Statewide Results

The statewide aggregate results presented in Table 3-7 are derived from the combined results of the four CHP+ MCOs. Table 3-7 shows the FY 2022–2023 MCO-level and statewide aggregate results for each CAHPS measure.[3-8]

Table 3-7—Statewide Comparison of Top-Box Scores

Measure	COA	DHMP	Kaiser	RMHP	Statewide Aggregate Score
Rating of Health Plan	64.8%	61.6%	66.4%	67.4%	64.8%
Rating of All Health Care	68.5%	67.6%	69.4%	67.8%	68.4%
Rating of Personal Doctor	76.3%	76.9%	75.3%	71.5%	75.5%
Rating of Specialist Seen Most Often	69.1%+	75.0%+	69.3%+	78.7%+	71.7%
Getting Needed Care	81.6%	80.1%+	78.8%	86.3%	81.9%
Getting Care Quickly	86.2%	79.3%+ ↓	83.3%	91.5% ↑	86.3%
How Well Doctors Communicate	94.9%	94.8%+	93.3%	96.5%	94.9%
Customer Service	90.7%+	82.5%+	84.7%+	86.8%+	88.8%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Statewide aggregate scores are added for reference.

↑ *Indicates the MCO's score is statistically significantly higher than the statewide aggregate score.*
↓ *Indicates the MCO's score is statistically significantly lower than the statewide aggregate score.*

Statewide Conclusions and Recommendations Related to CAHPS

The following CHP+ MCO's FY 2022–2023 CAHPS score was statistically significantly higher than the statewide aggregate score:

- RMHP (*Getting Care Quickly* )

The following CHP+ MCO's FY 2022–2023 CAHPS score was statistically significantly lower than the statewide aggregate score:

- DHMP (*Getting Care Quickly* )

[3-8] The CHP+ health plan results were case-mix adjusted to account for disparities in respondents' demographics for comparability among the health plans. Due to case-mix adjustment, the results of the four CHP+ MCOs may be different than the results in Section 4 of this report.

To address these low CAHPS rates, HSAG recommends the Department consider:

- Collaborating with each MCO to develop initiatives designed to improve processes that may impact parents'/caretakers' perceptions of the quality, timeliness, and accessibility of their child member's care.
- Determining if any best practices of RMHP can be shared and duplicated with DHMP regarding *Getting Care Quickly*.

For additional information about the CHP+ CAHPS activities and results for FY 2022–2023, refer to the aggregate CHP+ CAHPS report on the Department's website.[3-9]

QOC Grievances and Concerns Audit

Statewide Results

Table 3-8 presents the number of QOC grievances and concerns each CHP+ MCE reported during calendar year (CY) 2022, and the average CHP+ member population for each CHP+ MCE.

Table 3-8—Number of QOC Grievance and Concern Cases by MCE

	COA	COA Pop.	DHMP	DHMP Pop.	Kaiser	Kaiser Pop.	RMHP	RMHP Pop.	Denta-Quest	DentaQuest Pop.
# of QOC Cases/Population by MCE	4	42,869	0	4,276	2	7,510	4	9,052	3	48,737
# of QOC Cases—Total CHP+ Program	**13**									

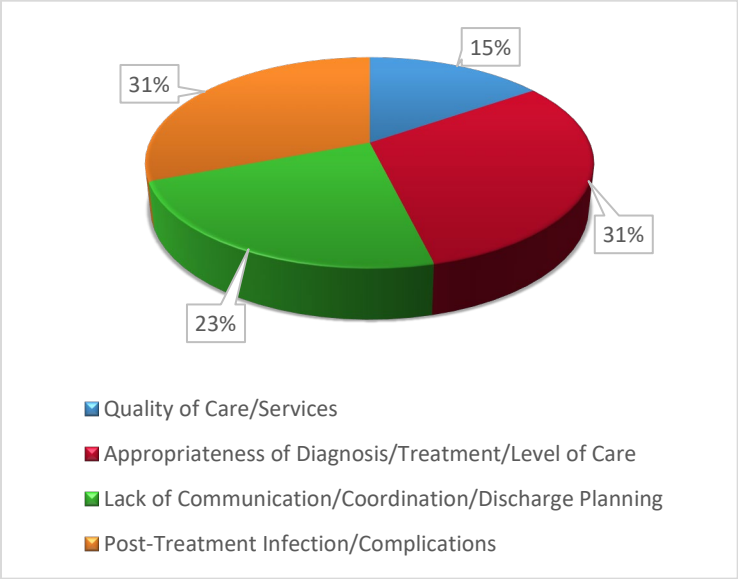
HSAG categorized the 13 cases reviewed into four broad categories of case type:

- Quality of care or service (in general terms)
- Appropriateness of treatment, diagnosis, or level of care
- Lack of communication, coordination, or discharge planning
- Post-treatment infection or complications

[3-9] Health Services Advisory Group, Inc. 2023 Colorado Child Health Plan Plus Member Experience Report, September 2023. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2023_CO%20CAHPS_CHP%2B_ExperienceRpt_Final.pdf. Accessed on: Dec 8, 2023.

Figure 3-10 presents the percentage of cases reported in each case type category.

Figure 3-10—Percentage of Case Types for the CHP+ Program



Statewide Conclusions and Recommendations Related to the QOC Grievances and Concerns Audit

Based on the FY 2022–2023 audit activities, HSAG identified the following strengths:

- All MCEs had processes for investigating QOC grievances and concerns or other QOC issues brought to the MCE.
- All MCEs except one followed stated policies and procedures.
- Two of the five MCEs used a two-factor rating scale to determine the severity level of the case investigated.
- All MCEs used a physician or equivalent (i.e., Doctor of Dental Surgery) level of reviewer to make a final determination regarding action needed (i.e., corrective action, monitoring, sanctions, etc.).
- Two MCEs had robust training for nonclinical staff members as well as for clinical staff members involved in identifying and/or investigating potential QOC issues or concerns, and actively encouraged staff members to refer potential cases for review.

Based on the FY 2022–2023 audit activities, HSAG found the following opportunities for improvement:

- While all MCEs submitted policies and procedures regarding QOC grievances and concerns, some MCEs did not specify operational definitions for QOC grievances and concerns; how the MCE

identifies, investigates, and processes QOC grievances and concerns; and/or staff member responsibilities to refer a QOC grievance and concern.

- Most MCEs described a rating system or severity rating scale used for QOC grievance and concern investigations; however, two MCEs did not have policies or procedures regarding using a rating system or scale, and one MCE did not provide implementation of this process within the cases reviewed.
- Three MCEs did not specify in policies and procedures detailed descriptions regarding expectations for nonclinical staff members to understand and determine which grievances should be referred to clinical staff members for further QOC review. These three MCEs also did not specify or indicate trainings for clinical staff members to engage and encourage critical review of cases for consideration for referral to quality management (QM) staff members for further review.
- None of the MCEs' policies and procedures contained all of the following details consistently:
  - Reporting QOC grievances and concerns to regulatory agencies.
  - Working with the Department to determine to which regulatory agencies the MCE should report.
  - Determining which QOC grievances and concerns the MCE should report to the Department and when.

To address these opportunities for improvement, HSAG recommends that the Department consider:

- Evaluating CHP+ MCE processes for identifying and investigating potential QOC grievances and concerns to determine best practices and identify a forum for sharing best practices among the MCEs. Additionally, HSAG suggests the Department encourage the MCEs to use a two-factor severity rating model to standardize categorizing QOC grievance and concern cases and determine next steps for investigating.
- Collaborating with the MCEs to develop consistent operational definitions for "quality of care," "QOC grievances," "QOC concerns," and other related definitions and to encourage more consistency in processes for handling QOC grievances and concerns across the CHP+ MCEs. HSAG suggests standardized trainings and checklists as helpful tools.
- Encouraging the MCEs to develop checklists, tools, and more robust QOC staff training to ensure nonclinical staff members understand expectations regarding determination of which grievances should be referred to clinical staff members for further review.
- Clarifying contract requirements with regard to reporting QOC grievances and concerns to regulatory agencies to determine which regulatory agencies should receive reporting of QOC grievances and concerns and under what circumstances. HSAG also recommends that the Department more clearly define the circumstances under which QOC investigations are reported to the Department and at what point in the investigation.

Colorado's CHP+ Managed Care Quality Strategy

Overview

The Department last assessed the effectiveness of the Quality Strategy in 2021 and makes updates when significant changes occur pursuant to any new regulatory requirements under 42 CFR §438.340. The Department's Quality Strategy review includes an evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. The Department's Quality Strategy is published to the Department's website and states that the Department takes public recommendations into consideration for updating the Quality Strategy. The Department, in alignment with the Governor's healthcare priorities, continues to focus on reducing healthcare costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive PH and BH services for the CHP+ population, and evaluates its effectiveness based on the following defined goals and objectives stated in the 2021 Quality Strategy Evaluation and Effectiveness Review:

- Healthcare Affordability for Coloradans: Reduce the cost of care in Colorado
- Cost Control: Ensure the right services for the right people at the right price
- Member Health: Improve member health
- Customer Service: Improve service to members, care providers, and partners

Colorado's Six Strategic Pillars

In addition to the goals and objectives outlined in the Department's Quality Strategy, Figure 1-1 displays the six strategic pillars the Department has defined to help focus its work on the Department's mission: *Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* The strategic pillars are reflected in the quality strategy goals selected by the Department and further supported through EQR work performed.

Figure 3-11—Colorado's Six Strategic Pillars

In consideration of the Department's goals and objectives and Colorado's six strategic pillars for performance management, HSAG provides the following recommendations to improve the quality, timeliness, and accessibility of care.

Healthcare Affordability for Coloradans: Reduce the cost of care in Colorado

HSAG recommends the Department:

- Implement proposed universal provider contracts to reduce administrative burden in the public health system, clarify roles for all parties, and encourage value-based payments (VBPs).
- Continue to encourage preventive services through its monitoring of associated performance measures, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) participation reports, and claims and utilization data.

Cost Control: Ensure the right services for the right people at the right price

HSAG recommends the Department:

- Evaluate network adequacy reports in conjunction with claims and utilization data to further assess network gaps and underutilization of services.
- Continue its support of telemedicine by:
  - Providing the MCEs with ongoing updates.
  - Clarifying the appropriate use of telemedicine.

  - Monitoring claims submissions to ensure accurate claims and track utilization trends.
  - Continuing to invest in broadband support for telemedicine opportunities to improve providers' connectivity, allowing providers to benefit from health information technology/health information exchange.
  - Soliciting recommendations directly from the MCEs to target specific providers who could benefit from additional technology supports (e.g., Community Mental Health Centers [CMHCs]; provider groups; and providers who experience barriers accessing admission, discharge, and transfer [ADT] feeds and/or coordinating the transition of care process).
- Consider focused VBPs and Alternative Payment Models (APMs) to address network gaps, particularly with SUD providers in rural and frontier counties, further supporting rural and frontier SUD providers with case management and transportation services.

Member Health: Improve member health

HSAG recommends the Department:

- Continue its implementation of CMS Core Set measures and increase its focus on working with the MCEs with low-performing HEDIS or Core Set measure rates.
- Evaluate the impact of the expanded pregnant and parenting member benefits to 12 months after birth.
- Encourage the MCEs to further invest in neighborhood health through community-based partnerships by supporting proven interventions that address social determinants of health (SDOH).
- Evaluate gaps in the availability of specific ASAM LOCs and access to SUD services.
- Support members' health literacy through the ongoing evaluation of Department and MCE critical member materials by ensuring accuracy, completeness, readability level, and timeliness of member communications. Examples of critical member materials include new enrollee welcome information, annual reminders, and special healthcare topics in member newsletters.

Customer Service: Improve service to members, care providers, and partners

HSAG recommends the Department:

- Further define care coordination and care management standards, referral procedures, and LOC expectations to monitor and measure outcome metrics for members with special health care needs (SHCN).
- Encourage the statewide adoption of additional evidence-based clinical practice guidelines (CPGs) and monitoring through clinical analytics.
- Consider the additional monitoring of member satisfaction across available datasets, such as CAHPS survey data, quarterly grievance reports, QOC reports, and disenrollment trends.

- Evaluate how its expanded efforts to connect children and families to coverage has impacted outcomes with a comparison of historical and present data, and evaluate for ongoing gaps in care or disparities that require additional focus for the pregnant and parenting population.
- Stipulate definitions for "grievances" and "QOC" in its contracts with the MCEs' definitions in order to work toward consistency in the members' experiences regarding the grievance, QOC, and appeals processes.

Summary and Assessment

The Department's Quality Strategy sets goals to improve the quality of healthcare and services furnished to its members by the MCEs. The Department's Quality Strategy includes a mechanism to monitor all federally required elements and evaluate performance of its MCEs by requiring the following:

- Calculating and reporting national performance measures, such as HEDIS and CAHPS, and custom-designed HEDIS-like measures.
- Internal auditing and monitoring to detect fraud, waste, and abuse.
- Regular monitoring of the MCEs' compliance programs.
- Participation in mandatory EQR activities as well as participation in custom-developed optional EQR activities designed to further specific Department goals and objectives.
- Ongoing assessments of quality and appropriateness of care.

HSAG recognizes the following programs and initiatives as best practices that are aligned with the Department's goals and objectives:

- The removal of premiums, deductibles, and most copays as of July 2023.
- The implementation of QUIPs that continue to assess the accuracy of encounter data.
- The implementation of PIP topics focused on how providers collect SDOH data.
- The development of a Health Equity Plan (HEP)[3-10] that applies a health equity lens across all programs and initiatives. The HEP aligns with the Governor's Executive Order 175, SB21-18, which focuses on addressing health disparities. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the CHP+ program's efforts on vaccinations, maternity and perinatal health, BH, and prevention, and aligns with CMS' Adult and Child Core Set measures. The Department provides member-level data (i.e., age, county, disability, gender, language, race, and ethnicity) to the MCEs to assist with identification of priority populations for healthcare initiatives. These efforts include ongoing work to close vaccination disparity gaps, maternity research and reporting, BH investments transformation, increasing access

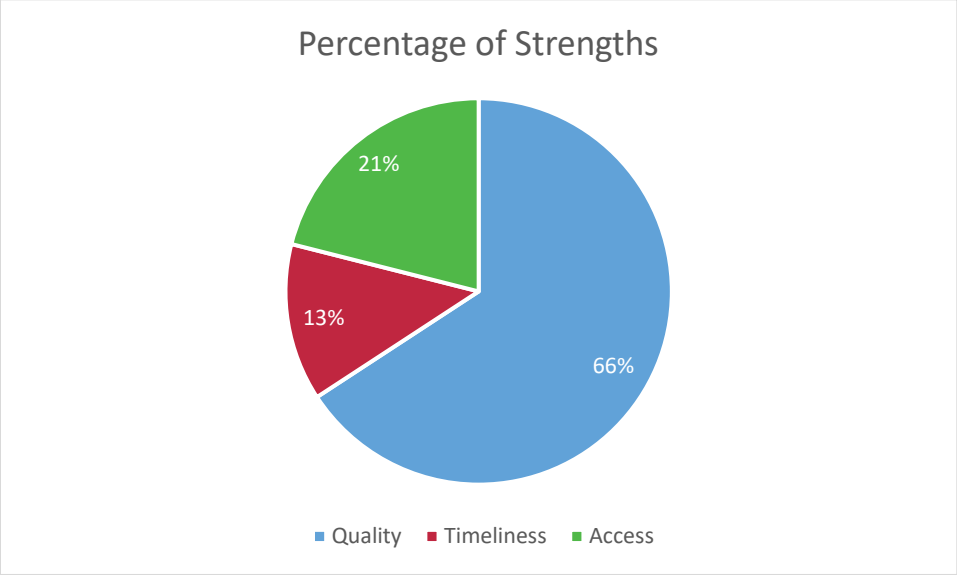
[3-10] Colorado Department of Health Care Policy & Financing. Department Health Equity Plan, Fiscal Year 2022–23. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Health%20Equity%20Plan.pdf. Accessed on: Jan 19, 2024.

to prevention, and expansion of quality care. These efforts may lead to performance measure rate improvement as the work progresses.

- The promotion of the Keep Coloradans Covered campaign, which focuses on informing members of their options at the end of the PHE.
- The historic passing of Health Benefits for Colorado Children and Pregnant People (HB22-1289), which waives CHP+ enrollment and renewal fees, creates a lactation benefit, and creates CHP+ look-alike programs for children and pregnant people without documentation.
- The Department's development of robust dashboards that stratify data to provide the current or most updated disparity data and embed a health equity lens in metric deliverables and analytics. The dashboard includes quality data; CMS Core Set measure data; and Department goals and measurements by race/ethnicity, gender, language, geography, disability, and other available identifiers. The dashboard also provides additional data that can be used by the CHP+ health plans to target interventions to improve performance measure rates. Notably, monitoring the CMS Core Set measures complements many of the Department's existing programs and initiatives, particularly the HEP.
- The use of eConsults to support primary care providers (PCPs) and to improve the referral process. eConsults allows asynchronous electronic clinical communications between primary care medical providers (PCMPs) and specialists. These efforts are expected to expand care in the PCP office by improving access while reducing specialist "no-shows."
- The implementation of Prescriber Tool Phase II, also known as the Social Health Info Exchange, which helps prescribe programs or communicate care coordinators' access to health improvement programs (i.e., prenatal care; diabetes supports; or SDOH, such as the Supplemental Nutrition Assistance Program [SNAP] and Women, Infants, and Children [WIC]).
- The initiatives noted above and planned for the ACC Phase III and the Alternative Payment Model 2 (APM 2) are strongly aligned with the Department's work related to the Division of Insurance's implementation of HB22-1325, which aims to enhance quality measures and quality reporting in a manner that is member-centered and member-informed as well as better aligned with overall systems to reduce provider administrative burden.

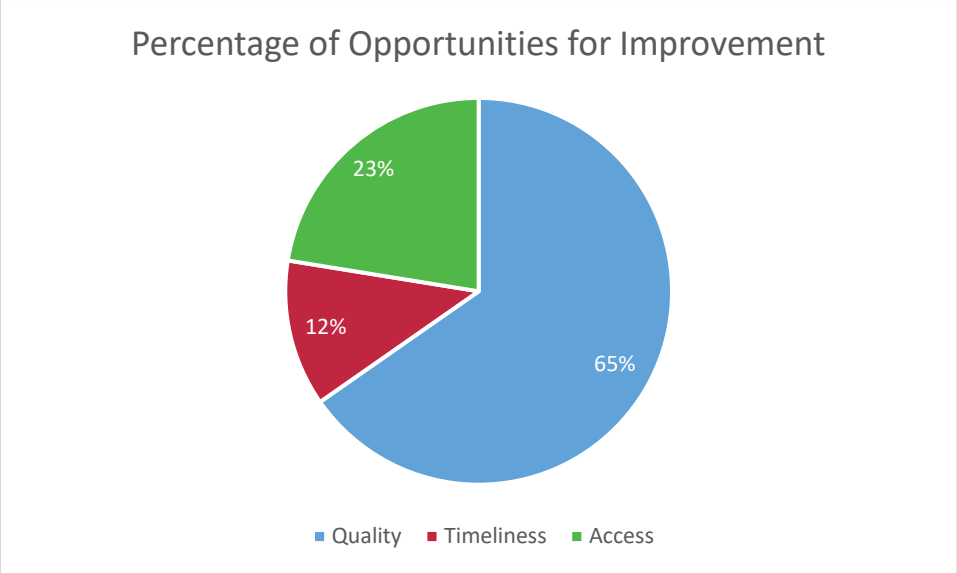
Colorado Access

Figure 4-1—Percentage of Strengths by Care Domain for COA*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 4-2—Percentage of Opportunities for Improvement by Care Domain for COA*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are COA's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, COA continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, COA established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process: Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021, and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-1 and Table 4-2 summarize COA's PIP activities that were completed and validated in FY 2020–2021. Table 4-1 provides the SMART Aim statements that COA defined for the two PIP outcome measures in Module 1.

Table 4-1—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in well visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.36% to 41.14%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement*	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-Up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers from 73.58% to 90.57%.

**The SMART Aim statement was revised in June 2021. HSAG approved revisions to the SMART Aim statement in June 2021 in response to COA's correction of data collection methods used to produce the baseline percentage.*

Table 4-2 summarizes the preliminary key drivers and potential interventions COA identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-2—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—Depression Screening	
Preliminary Key Drivers	• Provider standards of care and coding consistency. • Depression screening occurs at every well visit. • Member engagement and education. • Appointment availability and access.
Potential Interventions	• Standardization of depression screen scoring. • Provider education on appropriate coding practices. • Promotion of telehealth options for well visits. • Standardization of sick visit screening protocols. • Optimization of electronic health record (EHR) to support ordering and properly coding depression screens. • Automated well visit scheduling and reminder outreach. • Member education on appointment access and availability services.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider standards of care for BH referral process. • Provider education on appropriate BH follow-up coding practices. • Internal and external provider availability for BH follow-up visits. • Member access, knowledge, and engagement.
Potential Interventions	• Targeted provider education on effective referral processes. • Provider workflow improvement and standardization. • Provider education on appropriate coding practices. • Expand telehealth follow-up options through COA's free Virtual Care Collaboration and Integration (VCCI) program. • Develop member resources for BH and referral resources.

Table 4-3 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-3—Intervention Testing Plan for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Every Child Pediatrics depression screening coding change	• Incorrect coding for depression screening services by provider • EHR errors	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Financial stability and billing accuracy	• Percentage of well-visit claims with a corresponding depression screening Current Procedural Terminology (CPT) code (G8510 or G8431)
Peak Vista EHR optimization and coding changes: standardize depression screen scoring (positive and negative), adapt EHR to support ordering and coding of depression screening and follow-up services, provider education and best practices toolkit for depression screening and follow-up services and workflows	• Missed depressive symptoms • Lack of standardized depression screening instrument • Lack of provider awareness of appropriate codes • Providers unaware of unmet needs • EHR errors	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Standards of care: provider education, follow-up coding, and training • Financial stability and billing accuracy	• Percentage of members documented as "Watchful waiting; reassess at next visit" with a corresponding G8510 CPT code • Percentage of members documented as "Patients without a follow-up" with a corresponding G8510 CPT code • Percentage of members not documented as "PHQ-9[1] Declined," or "Medically Excluded from PHQ-9" with a corresponding depression screening code (G8510 or G8431) • Percentage of members documented as "PHQ-9 Declined" • Percentage of members documented as "Medically Excluded from PHQ-9" • Percentage of claims with a depression screening result code (G8510 or G8431) that were coded G8510

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of EHR to support protocol and coding standardization, using automation where possible	• Providers not aware of appropriate specification codes for the follow-up visit	• Financial stability and billing accuracy • Standards of care: provider education, follow-up coding, and training	• Percentage of well visits with a positive depression screening result, indicated by code G8431, with a follow-up service within 30 days, indicated by code H0002
A two-pronged approach to expanding BH services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the VCCI program for follow-up BH services via telehealth	• Follow-up visit is not occurring within 30 days of positive screen • Member is not reached for follow-up BH services • BH needs are not communicated to BH provider	• Standards of care: efficient referral processes • Internal and external BH provider availability • Financial stability and billing accuracy • Member access, knowledge, and engagement	• Percentage of available hiring and retention bonuses received by future and/or current BH staff (multiple measures) • Percentage of consults and therapy/assessments conducted via telehealth through the VCCI program (multiple measures)

[1]*PHQ = Patient Health Questionnaire*

FY 2022–2023 PIP Activities

In FY 2022–2023, COA continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed COA's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated COA's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for COA's PIP are presented in Table 4-4. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-4—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens in well visits among members ages 12 to 18 years who receive care at Every Child Pediatrics and Peak Vista Community Health Centers.	36.36%	41.14%	89.07%	Yes
Follow-Up After a Positive Depression Screen				
The percentage of *Follow-Up After a Positive Depression Screen* visits completed among members ages 12 to 18 years within 30 days of positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers.	73.58%	90.57%	82.86%	No

To guide the project, COA established goals of increasing the percentage of members 12 through 18 years of age who receive a depression screening during a well visit at Every Child Pediatrics and Peak Vista Community Health Centers from 36.36 percent to 41.14 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 73.58 percent to 90.57 percent, through the SMART Aim end date of June 30, 2022. COA's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 89.07 percent, representing a statistically significant increase of 52.71 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 82.86 percent, representing an improvement of 9.28 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, COA completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-5 summarizes COA's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-5—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Every Child Pediatrics depression screening coding change.	Significant *programmatic* improvement for *Depression Screening*	Adopted
Peak Vista Community Health Centers electronic health record (EHR) optimization and coding changes: standardize depression screen scoring (positive and negative), adapt EHR to support ordering and coding of depression screening and follow-up services, provide provider education and best practices toolkit for depression screening, and provide follow-up services and workflows.	*Programmatic* improvement for *Depression Screening* and *Follow-Up After a Positive Depression Screen*	Adapted
Every Child Pediatrics workflow and coding practices optimization: educate providers on best practices for coding and use of EHR to support coding standardization, using automation where possible.	*Evaluation results were inconclusive*	Adopted
A two-pronged approach to expanding BH services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the VCCI program for follow-up BH services via telehealth.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

COA: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for COA:

- COA developed and carried out a methodologically sound improvement project.
- COA accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure, and non-statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure.

- COA's intervention testing results also demonstrated programmatically significant improvement in *Depression Screening* and *Follow-Up After a Positive Depression Screen*, and clinically significant improvement in *Follow-Up After a Positive Depression Screen*, linked to the tested interventions.

COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

Based on PIP validation activities conducted in FY 2022–2023, COA's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of COA's PIP, HSAG recommended COA:

- Collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- Ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Assessment of COA's Approach to Addressing FY 2021–2022 PIP Recommendations

COA successfully addressed HSAG's FY 2021–2022 recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2022 FAR, COA was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted COA's performance measure reporting.

Performance Measure Results

Table 4-6 shows the performance measure results for COA for MY 2020 through MY 2022, along with the percentile rankings for each MY 2022 rate.

Table 4-6—Performance Measure Results for COA

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	42.81%	52.84%	**46.40%^^**	10th–24th
Ages 12 to 17 Years[H]	28.16%	44.86%	**39.27%^^**	<10th
Ages 18 to 21 Years[H]	53.14%	28.87%	**23.29%^^**	25th–49th
Total[H]	47.69%	48.16%	**41.86%^^**	10th–24th
Childhood Immunization Status				
DTaP[H]	78.26%	70.61%	66.42%	25th–49th
IPV[H]	87.97%	84.19%	80.81%	10th–24th
MMR[H]	88.27%	83.55%	80.07%	10th–24th
HiB[H]	87.46%	84.03%	79.70%	10th–24th
Hepatitis B[H]	87.06%	83.71%	**75.28%^^**	<10th
VZV[H]	86.55%	82.43%	79.52%	10th–24th
Hepatitis A[H]	82.81%	79.87%	78.23%	25th–49th
Pneumococcal Conjugate[H]	80.89%	76.52%	**70.48%^^**	25th–49th
Rotavirus[H]	77.15%	72.04%	68.82%	25th–49th
Influenza[H]	66.73%	62.30%	**51.48%^^**	50th–74th
Combination 3[H]	72.50%	65.97%	**57.93%^^**	10th–24th
Combination 7[H]	65.12%	57.35%	52.58%	25th–49th
Combination 10[H]	53.69%	46.81%	**37.64%^^**	50th–74th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	33.74%	34.66%	**29.07%^^**	<10th
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	—	48.04%	BTSA

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
2 Years[SA]	—	—	38.65%	BTSA
3 Years[SA]	—	—	23.06%	BTSA
Total[SA]	—	—	33.36%	BTSA
Immunizations for Adolescents				
Meningococcal[H]	77.81%	77.26%	**72.57%^^**	10th–24th
Tdap[H]	87.87%	85.20%	**82.00%^^**	25th–49th
HPV[H]	44.58%	40.39%	**35.45%^^**	25th–49th
Combination 1 (Meningococcal, Tdap)[H]	76.97%	76.45%	**71.79%^^**	10th–24th
Combination 2 (Meningococcal, Tdap, HPV)[H]	41.81%	37.74%	**33.31%^^**	25th–49th
Lead Screening in Children				
Lead Screening in Children[H]	—	—	30.88%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	13.69%	14.74%	16.27%	<10th
BMI Percentile—Ages 12 to 17 Years[H]	17.92%	18.65%	20.09%	<10th
BMI Percentile—Total[H]	15.33%	16.32%	17.90%	<10th
Counseling for Nutrition—Ages 3 to 11 Years[H]	10.14%	13.78%	19.07%^	<10th
Counseling for Nutrition—Ages 12 to 17 Years[H]	11.49%	14.12%	18.24%^	<10th
Counseling for Nutrition—Total[H]	10.66%	13.92%	18.71%^	<10th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	6.59%	8.44%	12.05%^	<10th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	9.25%	10.73%	14.74%^	<10th
Counseling for Physical Activity—Total[H]	7.62%	9.37%	13.20%^	<10th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	54.92%	61.19%	**52.51%^^**	25th–49th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	75.31%	65.48%	**55.06%^^**	10th–24th
Behavioral Health Care				
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	22.58%	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	29.03%	—
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	76.27%	≥90th
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	86.44%	≥90th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	36.42%	30.08%	10th–24th
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	54.91%	72.36%^	50th–74th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	33.78%	29.03%	36.62%	25th–49th
Continuation and Maintenance Phase[H]	46.94%	38.60%	52.83%	50th–74th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	40.82%	53.33%	48.48%	<10th
Blood Glucose Testing—Total[H]	40.80%	50.00%	47.62%	10th–24th
Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	18.37%	27.78%	21.21%	<10th
Cholesterol Testing—Total[H]	19.20%	27.19%	24.60%	<10th
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	18.37%	27.78%	20.20%	<10th
Blood Glucose and Cholesterol Testing—Total[H]	19.20%	27.19%	23.81%	<10th
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[H]	—	—	14.47%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	71.43%	67.35%	50th–74th
Total[H]	—	72.00%	64.41%	50th–74th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	—	16.44%	BTSA
LARC—Ages 15 to 20 Years[SA]	—	—	2.86%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	—	56.92%	**34.07%^^**	<10th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	68.97%	65.26%	<10th
Ages 12 to 18 Years[H]	—	81.98%	**51.09%^^**	<10th
Total (Ages 5 to 18 Years)[SA]	—	75.43%	**58.29%^^**	BTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	70.30%	—	81.48%	75th–89th
Use of Services				
Ambulatory Care: Emergency Department Visit*				
<1 Year[SA]	—	20.02	634.88	WTSA
Ages 1 to 9 Years[SA]	—	17.63	319.37	WTSA
Ages 10 to 19 Years[SA]	—	46.19	252.53	WTSA
Total (Ages 0 to 19 Years)[SA]	—	19.23	289.07	WTSA

** For this indicator, a lower rate indicates better performance.*
— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[SA] indicates that the measure could only be compared to the statewide average.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2021 to MY 2022.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.

COA: Strengths

The following HEDIS MY 2022 measure performance rates were determined to be high-performing rates for COA (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2021; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2021):

- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years* and *30-Day Follow-Up—Ages 6 to 17 Years* 
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17 Years* 

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* 

COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS MY 2022 measure rates were determined to be low-performing rates for COA (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2021):

- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*
- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 3*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years*
- *Immunizations for Adolescents—Combination 1* and *Combination 2*
- *Lead Screening in Children*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

To address these low rates, HSAG recommends COA:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS Measure Recommendations

FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG recommended COA:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommended COA coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[4-1]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[4-2]
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of COA's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

Based on the recommendations provided by HSAG, COA reported implementing the following:

- Newly enrolled CHP+ MCO members received a Health Risk Assessment (HRA) upon enrollment. HRA results were used by care managers to obtain a comprehensive understanding of each member's individual healthcare needs, including current risk factors, resource gaps or deficits, and overall quality of current care. HRA findings were loaded into the COA care management tool, and all member responses that indicated the need for follow-up care were assigned to a care manager for outreach. Coordination of care activities encompassed a broad range of care plan goals and interventions including, but not limited to, establishing a PCP to complete well-child visits, age-appropriate screenings, and immunizations; establishing BH services; scheduling dental visits; and helping members establish relationships with necessary specialty providers.

4-1 The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Dec 12, 2023.

4-2 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 12, 2023.

- An EPSDT well-check digital engagement program, which reminded members or parents/guardians of their annual insurance coverages while also informing members/guardians of the benefits of a wellness checkup, such as immunizations and healthy growth.
- The Text4Kids digital engagement program that targeted parents/guardians of CHP+ MCO members ages 0 to 17 years with text messages containing information and resources on child development and important milestones specific to the child's age. These messages included well-visit and vaccination reminders, such as HPV and vaccines children need to start school, information on developmental milestones, health education tailored to each child's age, and parenting tips.

COA reported strong member-, provider-, and community-facing interventions targeted to improve the QOC and timely access to healthcare services. HSAG recommends evaluating the effectiveness of the interventions and the observed impact the interventions have on performance rates. This includes but is not limited to evaluating the percentage of members who received text messages that resulted in a rendered service. Lastly, based on the effectiveness of the intervention, consider what a sustainability and spread plan would look like to target other service types that may benefit from these types of interventions.

Assessment of Compliance With CHIP Managed Care Regulations

COA Overall Evaluation

Table 4-7 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2022–2023.

Table 4-7—Summary of COA Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	34	30	4	0	0	88%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	31	31	28	3	0	0	90%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**78**	**7**	**0**	**0**	**92%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Table 4-8 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2022–2023.

Table 4-8—Summary of COA Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	70	56	14	30	80%
Grievances	60	51	51	0	9	100%
Appeals	60	57	52	5	3	91%
Totals	**220**	**178**	**159**	**19**	**42**	**89%***

**The overall record review score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

COA: Trended Performance for Compliance With Regulations

Table 4-9 displays COA's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 4-9—Compliance With Regulations Trended Performance for COA

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020, 2022–2023)	**78%**	**88%**
Standard II—Adequate Capacity and Availability of Services (2016–2017, 2019–2020, 2022–2023)	**100%**	**100%**
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	100%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	88%	100%
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021, 2022–2023)	**88%**	**90%**
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	100%	100%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	100%

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	89%	94%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*** **	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**For all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***In FY 2017–2018 all CHP+ health plans received a score of "NA" for the Subcontractual Relationships and Delegation standard. All requirements within this standard were new as of the 2016 managed care revisions, yet CHP+ health plans were not required to comply until FY 2018–2019.*

****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, COA demonstrated across each of the four standards consistently high-achieving and improved scores from the previous review cycle, indicating a strong understand of most federal and State regulations.

COA: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG identified the following strengths for COA:

- Policies, procedures, and reporting documents outlined a comprehensive UM approach to review and authorize covered services using medical necessity and InterQual criteria in compliance with regulatory guidelines. UM staff members participated in annual IRR testing to ensure criteria are applied consistently.
- The provider manual and website included accurate information regarding time and distance standards, and provider network and quality department staff members also outreached providers to inform them of timely appointment standards prior to conducting monitoring activities such as secret shopper. CAPs for providers who failed to comply with timely appointment standards were individualized based on the type of noncompliance documented and have shifted to an "opportunity" lens.
- Cultural competency efforts have been a focus in the organization, and staff members described that targeted outreach and engagement programs included the following member groups: Latinx, homeless, refugee, and members recently released from prison.
- Staff members described how they inform members of their rights if a member contacts COA to file a grievance and the ways the member or the member's authorized representative can submit a grievance. The member can submit a grievance by phone, email, online, or fax to customer service, care managers, or other staff members, and all staff are trained to submit grievances to the grievance team.

- When a member files an appeal, in addition to sending a written acknowledgement letter, the COA appeals coordinator verbally contacts the member to ensure that the member, or the member's representative, is aware that they have the right to submit documents, records, and other information, and that all comments will be considered by the decision maker without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to COA's system with no restriction.

COA: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- COA CHP+ templates and NABD samples did not mention the CYMHTA.
- The NABD letters to members did not include specific references to the clinical criteria (i.e., InterQual) reviewed.
- NABD letters included clinical terminology that may not be easy for the member to understand.
- COA did not mail an NABD letter to the member in two cases, and two additional cases were outside of the time frames.
- COA did not make two denial decisions within the required time frame.
- All NABD sample letters and templates included references to continuation of benefits, which is no longer applicable to the CHP+ LOB.
- Two sample denial records included EPSDT language that is also not applicable to the CHP+ LOB.
- NABD templates did not include information about the member's right to appeal under CYMHTA, when applicable.
- Geoaccess compliance reports, quarterly Network Reports, and the Network Adequacy Plan each included details of a few gaps in COA's provider network.
- One out of the 10 sample appeal records did not comply with the appeal acknowledgement letter time frame set forth by the State.
- An old policy inaccurately stated that the member must follow an oral request of an appeal in writing.

To address these opportunities for improvement, HSAG recommends COA:

- Update its procedures to further delineate provider claims issues that are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service in a timely manner.
- Include a reference to the health plan's criteria in the NABD.
- Include a plain language explanation next to any clinical terminology.
- Remove any references to continuation of benefits from all NABD letters and templates.
- Continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM LOCs 3.1, 3.3, 3.5, 3.7, 3.2 WM, and 3.7 WM), psychiatric hospitals, and psychiatric units in acute care hospitals.
- Enhance its monitoring procedures to ensure that members notices, such as NABDs, are sent to the member in a timely manner.
- Remove the statement that requires the member to follow an oral appeal request with a written appeal request.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- Send follow-up letters to members as a best practice, notifying members of the information and resources accessible to them.
- Update the Member Disability Rights Request and Complaint Resolution policy to clarify State verses Office of Civil Rights timelines and procedures for complaints.
- Conduct an annual review of denied providers to verify that any providers who were denied from joining COA's network were not discriminated against.
- Develop a method to collect, analyze, integrate, and report information related to disenrollment for reasons other than loss of eligibility, if and when COA staff members become aware of this information.

Assessment of COA's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 corrective action plan (CAP), COA updated policies and procedures to include a mechanism to collect, analyze, integrate, and report information related to disenrollment for reasons other than loss of eligibility. COA reported that data will be tracked and analyzed for any potential trends. HSAG recognizes that a mechanism to track and trend disenrollments for potential trends is likely to result in long-term improvements.

Validation of Network Adequacy

COA: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for COA:

- While COA did not meet all minimum network requirements across all counties in each county designation, COA demonstrated strength in the Pediatric Behavioral Health Practitioners and Pediatric Psychiatric Prescribers provider types, meeting the minimum network requirements in all contracted counties. In rural and frontier counties, COA met the minimum network requirements for Family Practitioners and Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA).
- COA had match rates above 90 percent for seven out of 10 PDV indicators.

COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

HSAG found the following opportunities for improvement:

- COA did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for 93 percent of the contracted counties.
- COA did not meet the minimum network requirements for more than 50 percent of the contracted counties for the following Pediatric Specialists: Endocrinology, Otolaryngology/ENT, Ophthalmology, Neurology, Urology, Pulmonary Medicine, Gastroenterology, and Cardiology.
- Overall, 42.3 percent of COA's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 43.6 percent were found at the sampled location. While COA noted that providers participating with a CMHC or other treatment center are not listed individually in the online provider directory, these providers are listed individually in the MCEs' provider data, resulting in a high rate of mismatched data for this indicator.
- COA had a match rate of 70.4 percent for the telephone number indicator.
- At 87.7 percent, COA had the second lowest match rate for the practitioner type/specialty across all MCEs.
- COA had a match rate of 11.2 percent for the accepting new patients indicator. However, accepting new patients information is missing from the COS online provider directory.

To address these opportunities for improvement, HSAG recommends COA:

- Continue to conduct an in-depth review of provider categories for which COA did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the

contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, COA should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure COA's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that COA seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of COA's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, COA reported taking the following actions:

- COA continues to seek opportunities to expand the care network, including Gynecology (Mid-Level) and the Pediatric Primary Care (Mid-Level practitioners) network categories, to ensure adequate network providers and access to care. Building on the foundation of the existing provider network, COA continued to use various resources to further target potential additions and grow the network of providers. COA has a dedicated provider contracting team that responds to inquiries and requests to participate in the network.
- COA is dedicated to contracting with every willing state-validated provider to become part of the provider network, regardless of their location, provided they meet the credentialing and contracting criteria.

Based on the above response, COA worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

CAHPS Survey

Findings

Table 4-10 shows the results achieved by COA for FY 2020–2021 through FY 2022–2023.

Table 4-10—Top-Box Scores for COA

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	66.4%	68.5%	64.1% ↓
Rating of All Health Care	72.8%	65.7%	68.4%
Rating of Personal Doctor	78.1%	75.4%	76.2%
Rating of Specialist Seen Most Often	67.1%	62.0%	70.4%+
Getting Needed Care	78.9%	83.3%	81.5%
Getting Care Quickly	85.7%	83.6%	86.2%
How Well Doctors Communicate	93.0%	97.4%	94.8%
Customer Service	87.4%+	92.5%	90.6%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

COA: Strengths

The following measures' FY 2022–2023 scores for COA were higher, although not statistically significantly, than the 2022 NCQA national averages:

- *How Well Doctors Communicate*
- *Customer Service*

The following measures' FY 2022–2023 scores for COA were higher, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*

COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

The following measure's FY 2022–2023 score for COA was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Health Plan*

To address this low CAHPS score, HSAG recommends COA implement appropriate interventions to improve the performance related to the care members need through the following, as applicable:

- Conduct root cause analyses or focus studies and obtain feedback from parents/caretakers on their child's recent office visit through a follow-up call or email to determine what could be driving parents'/caretakers' lower perceptions of the quality of the care and services their child member received.
- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Review the CAHPS communication plan for providing information about the ratings from the CAHPS survey to identify potential barriers to distributing this information to providers.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To follow up on recommendations related to the FY 2021–2022 CAHPS, COA reported engaging in the following QI initiatives:

- Collected and analyzed data from a fourth iteration of a member satisfaction survey administered in June 2022, and administered a fifth member satisfaction survey, which is currently being analyzed, in March 2023, to better understand member experience and perceptions of care. The former survey included questions that focus on scheduling, appointment access, and what COA could improve for members. The latter survey included survey questions that explored how members identify racially, culturally, and ethnically; how that identification impacts their healthcare experience; and how COA can improve the member experience.
- Developed and implemented a CAHPS communication plan in 2023. Information describing what the CAHPS survey is, the timeline for data collection, and the value it brings to members, providers, and the Health First Colorado system was communicated in the following venues: 1) provider manual, 2) quarterly provider newsletter, 3) internal COA employee newsletter, 4) member newsletter, and 5) COA social media platforms.

- Continued the COA customer service quality monitoring program in 2023, including continuous monitoring of Net Promoter Score (NPS) scores, customer service representative (CSR) quality audits, ongoing collaboration, and continued internal member satisfaction survey iteration and administration. If COA identifies trends, it provides additional to relevant departments.

Assessment of COA's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that COA addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with COA.

QOC Grievances and Concerns Audit

Findings

In CY 2022, COA investigated four potential QOC grievance/concern cases. COA's average CHP+ membership in CY 2022 was 42,869, with 32,585 members enrolled as of December 31, 2022. Of the four QOC grievance/concern cases investigated by COA, no cases were substantiated.

COA: Strengths

Based on QOC Grievances and Concerns Audit activities in FY 2022–2023, HSAG found the following strengths for COA:

- Within the four cases reviewed, professionals (i.e., those with a master's degree or a medical director) reviewed the QOC grievance or concern cases submitted to COA.
- COA's policies adequately described a process whereby the QM Department, with oversight by a medical director or physician designee, investigates, analyzes, tracks, trends, and determines actions or follow up needed in response to QOC concerns, and this process was demonstrated in the cases reviewed.
- During the interview, COA staff members stated that COA management encourages referrals from staff members to ensure that COA is looking into any potential issues and ensuring high QOC. HSAG identified this practice as a best practice.
- COA demonstrated a well-developed process with clear and concise forms, templates, and staff and provider training.
- COA implemented trainings for multiple internal departments within COA (i.e., UM and care management) that focused on QOC, which HSAG identified as a best practice.

COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- During the review period, customer service and grievance and appeal staff members were directed to refer member complaints to the QM team if the staff member feels the complaint is regarding something that could indicate potential harm to the member; however, there was no formal process or written checklist for staff members to follow.
- COA's policies and procedures did not specify the credentials or qualifications for the QM staff members who conduct the QOC concern reviews prior to review by the medical director.
- COA's policies and procedures described case-specific reporting to the Department only for cases referred by the Department.

To address these opportunities, HSAG recommends COA:

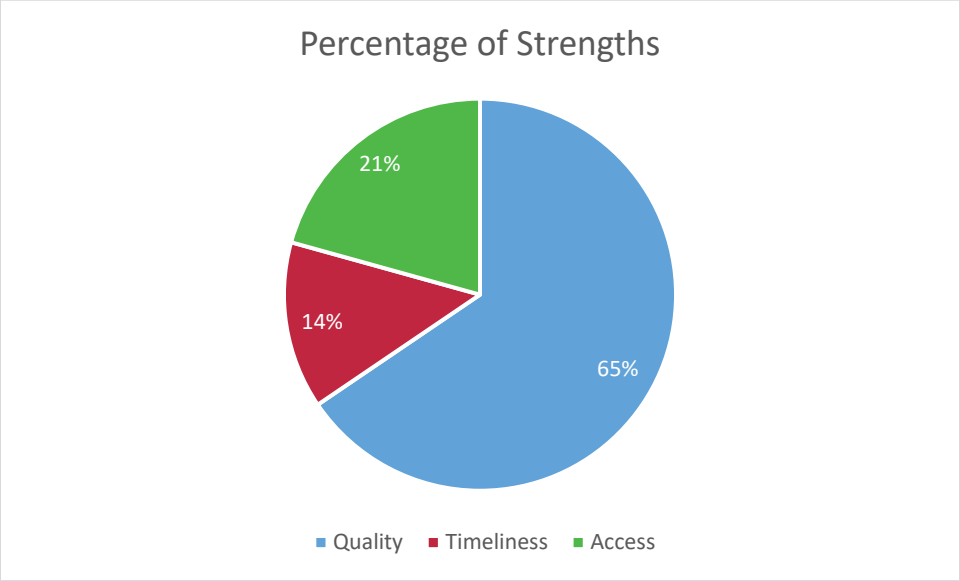
- Develop written criteria, checklists, or examples of situations that would indicate a referral to the QM team is warranted.
- Specify the required credentials for QOC concern review in its policies and procedures.
- Consider case-specific reporting to the Department at the time investigations are initiated and completed to ensure the Department is aware of any potential stakeholder actions or communications that may develop based on a specific concern. Additionally, COA may also want to consider working with the Department to determine if additional regulatory agencies should receive reporting of QOC grievances and concerns and under what circumstances.

Follow-Up on FY 2021–2022 Recommendations

The QOC Grievances and Concerns Audit was not conducted for CHP+ MCEs in FY 2021–2022.

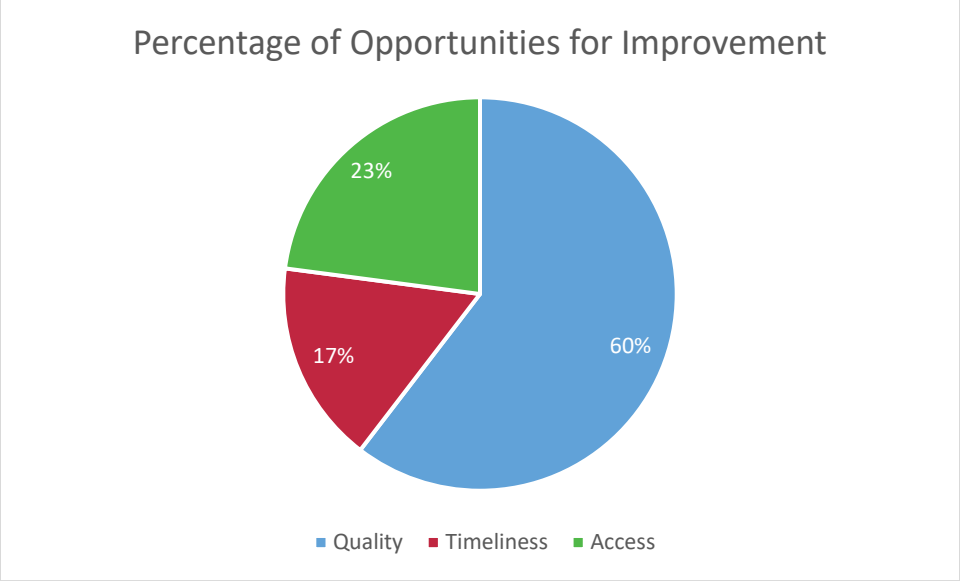
Denver Health Medical Plan, Inc.

Figure 4-3—Percentage of Strengths by Care Domain for DHMP*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 4-4—Percentage of Opportunities for Improvement by Care Domain for DHMP*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are DHMP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, DHMP established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process: Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021, and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-11 and Table 4-12 summarize DHMP's PIP activities that were completed and validated in FY 2020–2021. Table 4-11 provides the SMART Aim statements that DHMP defined for the two PIP outcome measures in Module 1.

Table 4-11—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH, from 62.11% to 70.18%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement*	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH from 55.56% to 81.48%.

**The SMART Aim statement was revised in February 2022. HSAG approved revisions to the SMART Aim statement in February 2022 in response to DHMP's correction of data queries used to produce the baseline percentage and goal.*

Table 4-12 summarizes the preliminary key drivers and potential interventions DHMP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-12—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of depression screening in EMR and data systems. • Adequate appointment length to allow for depression screening.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation. • Expand inclusion of depression screening as a standard service provided at all primary care acute visits.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of BH follow-up services in EMR and data systems. • Adequate appointment length to address positive depression screen. • Attendance of scheduled BH follow-up appointment.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation. • Same-day warm handoff to in-clinic BH provider following positive depression screen.

Table 4-13 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-13—Intervention Testing Plan for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Expand depression screening services to all primary care acute (sick) visits in addition to well visits	Member declines well visit	Member attends a visit annually (when depression screening services would typically be provided)	The percentage of acute visits attended by adolescent members during which a depression screening was completed and documented in Epic
Same-day warm hand-off to in-clinic BH provider when a member screens positive for depression	Member does not attend follow-up BH appointment	Member attends follow-up BH visit after a positive depression screen	The percentage of adolescent members who screen positive for depression and receive a same-day BH visit or have a follow-up plan documented in the EHR stating that the member is already engaged in BH services

FY 2022–2023 PIP Activities

In FY 2022–2023, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed the initial Module 4 submission form, provided initial feedback to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

HSAG analyzed DHMP's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated DHMP's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for DHMP's PIP are presented in Table 4-14. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-14—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of members who received at least one depression screening annually among Denver Health CHP+ members ages 12–21 years assigned to the Westside Pediatrics PCMH.	62.11%	70.18%	75.55%	*Yes*
Follow-Up After a Positive Depression Screen				
The percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health CHP+ members ages 12–21 years assigned to the Westside Pediatrics PCMH.	55.56%	81.48%	66.67%	*No*

To guide the project, DHMP established goals of increasing the percentage of members 12 through 21 years of age assigned to Westside Pediatrics PCMH who received an annual depression screening from 62.11 percent to 70.18 percent and increasing the percentage of those members who received BH services within 30 days of screening positive for depression from 55.56 percent to 81.48 percent, through the SMART Aim end date of June 30, 2022. DHMP's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 75.55 percent, representing a statistically significant increase of 13.44 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 66.67 percent, representing an improvement of 11.11 percentage points over the baseline rate, which was not statistically significant.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, DHMP completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-15 summarizes DHMP's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-15—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Expand depression screening services to all primary care acute (sick) visits in addition to well visits.	Significant *programmatic* and *clinical* improvement for *Depression Screening*	Adopted
Same-day warm handoff to in-clinic BH provider when a member screens positive for depression.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

DHMP: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP developed and carried out a methodologically sound improvement project.
- DHMP accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated statistically significant improvement over baseline performance for the *Depression Screening* measure, and improvement over baseline performance that was not statistically significant for the *Follow-Up After a Positive Depression Screen* measure.
- DHMP's intervention testing results also demonstrated clinically, and programmatically significant improvement linked to the tested interventions for both measures.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

Based on PIP validation activities conducted in FY 2022–2023, DHMP's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of DHMP's PIP, HSAG recommended DHMP:

- Collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- Ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Assessment of DHMP's Approach to Addressing FY 2021–2022 PIP Recommendations

DHMP successfully addressed HSAG's FY 2021–2022 recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2022 FAR, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted DHMP's performance measure reporting.

Performance Measure Results

Table 4-16 shows the performance measure results for DHMP for MY 2020 through MY 2022, along with the percentile rankings for each MY 2022 rate.

Table 4-16—Performance Measure Results for DHMP

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	42.93%	52.41%	**46.24%^^**	10th–24th
Ages 12 to 17 Years[H]	35.26%	46.37%	44.11%	10th–24th
Ages 18 to 21 Years[H]	50.12%	25.43%	28.88%	50th–74th
Total[H]	46.11%	47.87%	**43.71%^^**	25th–49th
Childhood Immunization Status				
DTaP[H]	81.94%	60.00%	81.58%^	≥90th
IPV[H]	88.89%	68.00%	86.84%^	50th–74th
MMR[H]	86.11%	78.00%	84.21%	50th–74th
HiB[H]	87.50%	74.00%	84.21%	50th–74th
Hepatitis B[H]	94.44%	58.00%	89.47%^	75th–89th
VZV[H]	86.11%	76.00%	81.58%	25th–49th
Hepatitis A[H]	84.72%	78.00%	81.58%	50th–74th
Pneumococcal Conjugate[H]	83.33%	64.00%	81.58%^	≥90th
Rotavirus[H]	80.56%	54.00%	73.68%^	75th–89th
Influenza[H]	66.67%	60.00%	55.26%	50th–74th
Combination 3[H]	81.94%	52.00%	78.95%^	≥90th
Combination 7[H]	75.00%	48.00%	68.42%^	≥90th
Combination 10[H]	63.89%	44.00%	52.63%	≥90th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	44.29%	38.33%	42.31%	10th–24th
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	—	NA	—

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
2 Years[SA]	—	—	75.00%	BTSA
3 Years[SA]	—	—	41.07%	BTSA
Total[SA]	—	—	55.12%	BTSA
Immunizations for Adolescents				
Meningococcal[H]	91.33%	66.10%	83.45%^	50th–74th
Tdap[H]	90.00%	66.10%	83.45%^	25th–49th
HPV[H]	55.33%	43.50%	46.76%	75th–89th
Combination 1 (Meningococcal, Tdap)[H]	88.00%	64.97%	82.73%^	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)[H]	54.00%	42.94%	46.76%	75th–89th
Lead Screening in Children				
Lead Screening in Children[H]	—	—	61.54%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	63.72%	71.28%	65.34%^	10th–24th
BMI Percentile—Ages 12 to17 Years[H]	64.27%	73.94%	63.89%^	10th–24th
BMI Percentile—Total[H]	63.96%	72.47%	64.65%^	10th–24th
Counseling for Nutrition—Ages 3 to 11 Years[H]	72.30%	79.22%	72.31%^	25th–49th
Counseling for Nutrition—Ages 12 to 17 Years[H]	67.86%	75.89%	67.40%	25th–49th
Counseling for Nutrition—Total[H]	70.36%	77.72%	69.97%^	25th–49th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	71.64%	78.50%	70.92%^	50th–74th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	67.69%	75.89%	67.18%	25th–49th
Counseling for Physical Activity—Total[H]	69.92%	77.33%	69.13%^	50th–74th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	64.52%	50.00%	NA	—
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	66.18%	63.29%	63.89%	25th–49th
Behavioral Health Care				
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	NA	NA	NA	—
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Total[H]	NA	NA	NA	—
Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Cholesterol Testing—Total[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	NA	NA	NA	—
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[H]	—	—	33.60%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	NA	NA	—
Total[H]	—	NA	NA	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	—	9.32%	BTSA
LARC—Ages 15 to 20 Years[SA]	—	—	1.43%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	—	NA	75.00%	10th–24th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	NA	NA	—
Ages 12 to 18 Years[H]	—	NA	NA	—
Total (Ages 5 to 18 Years)[SA]	—	NA	NA	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	NA	—	NA	—
Use of Services				
Ambulatory Care: Emergency Department Visit*				
<1 Year[SA]	—	14.97	726.82	WTSA
Ages 1 to 9 Years[SA]	—	11.40	301.35	WTSA
Ages 10 to 19 Years[SA]	—	34.29	139.35	BTSA
Total (Ages 0 to 19 Years)[SA]	—	13.31	218.97	BTSA

** For this indicator, a lower rate indicates better performance.*
— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[SA] indicates that the measure could only be compared to the statewide average.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2021 to MY 2022.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.

DHMP: Strengths

The following HEDIS MY 2022 measure rates were determined to be high-performing rates for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2021; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2021):

- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*
- *Immunizations for Adolescents—Combination 1* and *Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS MY 2022 measure rates were determined to be low-performing rates for DHMP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2021):

- *Child and Adolescent Well-Care Visits—Total*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

To address these low rates, HSAG recommends DHMP:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS Measure Recommendations

FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG recommended DHMP:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommended DHMP coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[4-3]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[4-4]
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of DHMP's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

Based on the recommendations provided by HSAG, DHMP reported implementing the following:

- An expanded partnership and collaboration in QI workgroup activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, and annual visits. Workgroups were established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated BH, transitions of care, immunizations, and ambulatory care Quality Improvement Committee.
- For the measures related to well-child visits, EPSDT, and immunizations, DHMP reported implementing the following interventions:
  - Enhanced efforts for wraparound services outside of the health plan, and for tracking of referrals for services outside the health plan, by network providers. Additionally, improved the number of EPSDT services tracked at ACS, available by clinic and provider.
  - Distributed Healthy Hero Birthday Cards, which were sent to members ages 19 and younger, that provided a checklist with information on healthy eating, development, vaccines, and physical activity. The birthday cards were intended to provide visit reminders as well as prepare and educate children and parents on what will happen at upcoming well-child visits. The card also included how to schedule a well-child appointment. For SFY 2022–2023, DHMP mailed an average of 1,435 birthday cards a month to Medicaid Choice members and an average of 105 birthday cards a month to CHP+ members.
  - Began using text messages sent three days before a well-child appointment for ages 3 years and older to the parent/guardian on file to remind them of their child's upcoming important well-child visit. DHMP also sent important paperwork through MyChart for families to review and fill out prior to the appointment to facilitate a smoother check-in process and better information sharing.

[4-3] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Dec 12, 2023.

[4-4] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 12, 2023.

  - Phone calls to parents/guardians when children missed a well-child visit at 1, 2, 4, and 6 months within 24 hours of the missed appointment to help them reschedule. This helps keep families on track for important visits, screenings, and immunizations in the first year of life.
  - Continued the use of school-based health centers (SBHCs): Denver Health Medicaid Choice and CHP+ members. SBHCs provided a variety of services such as well-child visits, sports physicals, immunizations, chronic disease management, primary care and BH services. DHMP continued to encourage eligible members to access care through the network of SBHCs. This information was sent directly to member households in newsletters and was also available on its website. In addition, the appointment center utilized a process that alerted schedulers of SBHC-enrolled students, which sends prompts to schedule children at an SBHC for their clinic needs. Additionally, students could directly schedule an appointment at their SBHC through their MyChart account.
- For the *Breast Cancer Screening* measure, DHMP implemented the following interventions:
  - Distributed monthly mammogram mailers were sent to members due for mammography. The mailer included information on scheduling an appointment as well as a link to a calendar for the women's mobile clinic that allowed members to schedule a mammogram at their home clinic and avoid travel to the Denver Health and Hospital Authority (DHHA) main campus. DHMP sent mammogram reminder mailers to 6,826 female Medicaid members between July 1, 2022, and June 30, 2023.
- For measures related to asthma interventions, DHMP implemented the following interventions:
  - The Asthma Work Group and registered nurse (RN) line utilized a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. Members were also informed about the need to make an asthma assessment appointment with their PCPs if they have refilled their rescue medication without refilling the appropriate number of controller medications.
  - Conducted a follow-up phone call within 48 hours of discharge from the emergency department (ED) or an inpatient stay for pediatric members with an asthma-related concern. Patient navigators (PNs) were tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a transition of care flowsheet.
- For the measures related to access to care, DHMP implemented the following interventions:
  - Denver Health continued to operate 18 SBHCs that provide healthcare in an easy and convenient setting to all plan members who attend Denver Public Schools.
  - Several strategies were developed to reduce the wait list, including an improved new patient workflow for the Appointment Center, the hiring and placement of providers in key locations, collaboration between the Appointment Center and clinics to fill open appointment slots, and adjusted provider panel sizes. Saturday morning hours for primary care at three locations have continued at the Montbello Health Center, Denver Health main campus, and at the Westside Family Health Center on Federal Boulevard.
  - Provided members with information on how to access the care they need through the Provider Directory, Member Handbook, and Member Newsletters. These materials provided information on how to obtain primary care, specialty care, after-hours care, emergency care, ancillary care,

and hospital services. The Denver Health Member Handbook contains information on member benefits and how to access care within the DHMP network.

- Distributed a welcome packet to new members that included their ID card and Quick Reference Guide. DHMP also provides orientation videos in English and Spanish on the website for members. These videos informed its members about their benefits and provided information on how the plan works.
- DHMP maintained a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine was capable of discussing the members' symptoms and concerns, assisting members in understanding the urgency of their needs, and helping members decide the best course of action based on the urgency to see their PCP or going to the urgent care or ED. Additionally, the NurseLine nurses could write prescriptions for some illnesses and could also schedule a Dispatch Health visit.
- DHMP continued to contract with Dispatch Health to support the membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. DHMP has expanded the use of Dispatch Health to include skilled nursing facility (SNF) at home, hospital at home, and bridging services to assist in early discharges.
- Continued to use MyChart, which is a user-friendly application/website with multiple capabilities available to members to enhance and support their experiences. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, reviewing lab results, communicating directly with providers, and providing a centralized location for tracking health outcomes and programs. It was used to send mass messages about the availability of COVID-19 and flu vaccines, as requirements changed rapidly.
- Began utilizing an e-consult process that allowed providers to refer members for an e-consult with a specialist who can review the case and provide recommendations for care without, in many cases, having to see the member for a visit. E-consults are generally acted on within three business days. This resulted in less wait times for specialty access. In the event that a follow-up visit was needed, the specialty provider can order a visit.
- Continued to offer telehealth visits for members. Members can schedule telehealth visits, including urgent care, via MyChart.
- Continued to contract with STRIDE Community Health Center. The partnership added 15 additional clinic locations (three of which have pharmacies on-site) and options for members.

DHMP reported strong member-, provider-, and community-facing interventions targeted to improve the QOC and timely access to healthcare services. Additionally, DHMP reported strong partnerships and collaboration with the community and the provider network to engage across all service levels, exhibiting extensive commitment and efforts for continuous improvement. HSAG recommends evaluating the effectiveness of the interventions and the observed impact the interventions have on performance rates. This includes but is not limited to evaluating the percentage of members who received mailers and birthday cards that resulted in a rendered service. Lastly, based on the effectiveness of the intervention, determine the sustainability and spread plan to target other service types that may benefit from these types of interventions.

Assessment of Compliance With CHIP Managed Care Regulations

DHMP Overall Evaluation

Table 4-17 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2022–2023.

Table 4-17—Summary of DHMP Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	34	33	1	0	0	97%
II. Adequate Capacity and Availability of Services	14	14	13	1	0	0	93%
VI. Grievance and Appeal Systems	31	31	24	7	0	0	77%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**76**	**9**	**0**	**0**	**89%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Table 4-18 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2022–2023.

Table 4-18—Summary of DHMP Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	61	51	10	39	84%
Grievances	NA	NA	NA	NA	NA	NA
Appeals	36	32	27	5	4	84%
Totals	**136**	**93**	**78**	**15**	**43**	**84%***

**The overall record review score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

DHMP: Trended Performance for Compliance With Regulations

Table 4-19 displays DHMP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 4-19—Compliance With Regulations Trended Performance for DHMP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020, 2022–2023)	**97%**	**97%**
Standard II—Adequate Capacity and Availability of Services (2016–2017, 2019–2020, 2022–2023)	**88%**	**93%**
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	60%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	100%	100%
Standard V—Member Information Requirements (2017–2018, 2020–2021)	83%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021, 2022–2023)	**94%**	**77%**
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	79%	93%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	100%	97%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	89%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*****	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**For all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***In FY 2017–2018 all CHP+ health plans received a score of "NA" for the Subcontractual Relationships and Delegation standard. All requirements within this standard were new as of the 2016 managed care revisions, yet CHP+ health plans were not required to comply until FY 2018–2019.*

****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, DHMP demonstrated consistently high-achieving scores in three of the four standards reviewed and improvement from the previous review year for one of the four standards reviewed. Standard I—Coverage and Authorization of Services scored consistently high, Standard II—Access Capacity and Availability of Services improved by 5 percentage points compared to the previous review year, and Standard XII—Enrollment and Disenrollment was high achieving. However, Standard VI—

Grievance and Appeal Systems declined by 17 percentage points compared to the previous review, indicating a moderate understanding of most federal and State regulations.

DHMP: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG identified the following strengths for DHMP:

- IRR testing most recently occurred in August 2022, and staff members reported that the passing rate was 97 percent.
- The DHHA Annual Training included topics related to cultural competency such as embracing diversity, ensuring inclusion, maximizing positive interactions with members and their caregivers/family, and other methods to ensure members feel "comfortable, cared for, and valued." Staff members described ongoing targeted efforts for lesbian, gay, bisexual, transgender, and queer, criminal justice, foster care, and refuge members, and the training addressed ways to support members with body type diversity to ensure correctly sized medical equipment.
- When a provider filed an appeal on behalf of a member, in addition to sending a written acknowledgement letter to the member, DHMP verbally contacted the provider to request additional documents and inform the provider that documents could be submitted via Epic Systems Corporation's online system.
- Appeal notices were written at approximately a sixth-grade reading level.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to DHMP's system with no restriction.

DHMP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- Policy language included a definition of "medical necessity" across multiple documents; however, it did not fully detail extension procedures or NABD procedures.
- Some NABDs included language that may be confusing to the member, such as "not a covered benefit" when the denial is solely regarding out-of-network requests.
- DHMP's NABD included references indicating that members must submit a signed copy of an appeal and references to continuation of benefits (which no longer apply to CHP+). The NABD did not include the date when the appeal is due; that members may receive a copy of their file, *at no cost,* upon request; that a State fair hearing may be requested within 120 days from the adverse

appeal resolutions; and did not clarify peer-to-peer reviews after issuance of the NABD will occur as part of the appeal process.

- The Provider Access Survey presentation from CY 2022 Quarter 3 (Q3) indicated that contracted providers had low compliance with timely appointments.
- Handbooks included both PH and BH appointment timeliness content but did not clarify that well-visits may be shorter than one month if indicated by the Bright Futures Periodicity Schedule. Additionally, the Network Plan incorrectly stated that urgently needed services are available within 48 hours of request by the member or the member's provider(s).
- The Appeal Process stated that a specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days. This procedure is inconsistent with the federal updates that no longer require an appeal to be submitted in writing. Additionally, the CHP+ Member Handbook incorrectly stated that the member must sign and return a written appeal.
- DHMP's CHP+ Member Handbook, the "After you file an appeal" section of the CHP+ website, and DHMP's NABDs stated that the member or member's representative "may look" at the case file before and during the appeal process, DHMP did not inform members that the request is free of charge.
- One DHMP CHP+ appeal resolution letter would not have been easy for the member to understand.
- The DHMP CHP+ website stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal regulation set forth the time frame for expedited resolution to not exceed 72 hours.
- DHMP CHP+ appeal resolution letters, the CHP+ Member Handbook, and the CHP+ website inaccurately stated that the member can request continuation of benefits while the State fair hearing is pending and how to make that request.
- The "State Fair Hearing" section of DHMP's CHP+ website and its Provider Manual did not clarify that if an appeal was resolved in the member's favor, services will be provided no later than 72 hours from the date DHMP receives notice reversing the determination.
- The Provider Manual included inaccurate information regarding the time frame for expedited appeals.

To address these opportunities for improvement, HSAG recommends DHMP:

- Revise policies to include a cohesive definition of "medical necessity" with all ASAM and EPSDT definitions, and clarify extension procedures and NABD procedures.
- Update NABD template language to remove language that may be confusing to the member, such as "not a covered benefit" when the denial is solely regarding out-of-network requests.
- Make changes to the NABDs to remove references indicating that members must submit a signed copy of an appeal and references of continuation of benefits. The NABD must include the date the appeal is due; that members may receive a copy of their file, *at no cost,* upon request; that a State fair hearing may be requested within 120 days from the adverse appeal resolutions; and clarify peer-to-peer reviews after issuance of the NABD will occur as part of the appeal process.
- Reintroduce CAPs to providers with low compliance with timely appointment standards when the focus of larger efforts begins to move away from the COVID-19 PHE.
- Include the Bright Futures Periodicity Schedule regarding well-care appointment timeliness standards and ensure the Network Plan includes the 24-hour urgent care timeliness requirement in the CHP+ member handbook.
- Remove any language from both the Appeal Process and CHP+ Member Handbook that requires the member to sign and return a written appeal.
- Update the CHP+ Member Handbook and CHP+ website to inform the member and member's representative that DHMP will provide the case file to the member or the member's representative, including medical records, other documents, and records, and any new or additional documents considered, relied on, or generated by DHMP in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.
- Remove any language that is deemed confusing and that could potentially confuse the member.
- Update the CHP+ website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours set forth by federal and State regulations.
- Remove all language that references continuation of benefits in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website as this does not apply to the CHP+ LOB.
- Revise the "State Fair Hearing" section of its CHP+ website and the "Effectuation of Appeal Resolutions" section of its Provider Manual to clarify that DHMP will provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.
- Update the Provider Manual to incorporate the time frame of a decision regarding an expedited appeal, State fair hearing, and appeal request.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- Include in its policy or procedure an annual process to retrospectively review declined provider data to validate that the process of redacting demographic identifiers proved sufficient to ensure that declined providers were not declined based on discrimination.
- Expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.
- Review internal procedures for handling credentialing data and ensure accuracy when staff verification and medical director approval occur. DHMP should consider timely monitoring of quality issues and complaints.

Assessment of DHMP's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, DHMP developed a mechanism to conduct an audit to enhance accuracy and consistency with credentialing data. HSAG recognizes that a mechanism to track and audit accuracy and consistency with credentialing data is likely to result in long-term improvements.

Validation of Network Adequacy

DHMP: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for DHMP:

- DHMP met the minimum network requirements for General and Pediatric Behavioral Health Practitioners, General and Pediatric Psychiatrists and other Psychiatric Prescribers, Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS, PA), and all General Specialties and Pediatric Urology Practitioners across all contracted counties.
- Based on the PDV results, strengths were not identified for DHMP.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

HSAG found the following opportunities for improvement:

- DHMP did not meet the minimum network requirements for OB/GYN (PA) and Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals for any of its contracted counties.

- DHMP did not meet the minimum network requirement for Acute Care Hospitals for 75 percent of the contracted counties; however, of those not meeting, they were within in 2 percent of meeting the minimum network requirements.
- Overall, 68.1 percent of DHMP's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 21.7 percent were found at the sampled location.
- DHMP had a match rate of 83.1 percent for the street address indicator.
- At 55.1 percent, DHMP had the second lowest match rate for the telephone number indicator.
- DHMP had a match rate of 14.6 percent for the accepting new patients indicator. However, accepting new patients information was not readily available in the DHMP online provider directory.
- At 43.7 percent, DHMP had the second lowest match rate for the practitioner gender indicator.

To address these opportunities for improvement, HSAG recommends DHMP:

- Continue to conduct an in-depth review of provider categories for which DHMP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies.
- Test its internal oversight processes against HSAG's directory review findings to identify oversight processes and/or reporting that should be enhanced. In addition to updating provider data and directory information, DHMP should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
- Ensure all required provider directory indicators (e.g., accepting new patients) are displayed in the online provider directory.
- Ensure DHMP's full network of providers is displayed in the online provider directory to align with other provider data reporting mechanisms.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that DHMP seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of DHMP's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, DHMP reported taking the following actions:

- To support providers, DHMP maintained the provider portal. The portal allows providers direct and immediate access to their information, including but not limited to benefits, member eligibility, accumulators, claims inquiry (submission, replace, void), referral/authorization inquiry (submission, review), and secure messaging. DHMP reported exploring improvements and upgrades to bring in additional features in the coming year.
- DHMP continued to engage Department staff members in conversations around challenges with members that reside outside of the DHMP service area.

Based on the above response, DHMP worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

CAHPS Survey

Findings

Table 4-20 shows the results achieved by DHMP for FY 2020–2021 through FY 2022–2023.

Table 4-20—Top-Box Scores for DHMP

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	70.9%	65.8%	61.5% ↓
Rating of All Health Care	76.5%	66.1%	66.9%
Rating of Personal Doctor	82.8%	78.4%	76.1%
Rating of Specialist Seen Most Often	71.2%+	66.7%	73.3%+

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Getting Needed Care	83.4%	68.2%	78.8%+
Getting Care Quickly	86.2%	77.2%	78.5% ↓
How Well Doctors Communicate	94.9%	93.8%	94.5%+
Customer Service	87.0%	82.4%	82.7%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

DHMP: Strengths

The following measures' FY 2022–2023 scores for DHMP were higher, although not statistically significantly, than the 2022 NCQA national averages:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

The following measures' FY 2022–2023 scores for DHMP were higher, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

The following measures' FY 2022–2023 scores for DHMP were statistically significantly lower than the 2022 NCQA national averages:

- *Rating of Health Plan*

- *Getting Care Quickly*

To address these low CAHPS scores, HSAG recommends DHMP implement appropriate interventions to improve the performance related to the care members need through the following, as applicable:

- Conduct root cause analyses or focus studies and obtain feedback from parents/caretakers on their child's recent office visit through a follow-up call or email to determine what could be driving parents'/caretakers' lower perceptions of the quality and timeliness of the care and services their child member received.
- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Evaluate the process of care delivery and identify if there are any operational issues contributing to access to care barriers for members.
- Direct parents/caretakers of child members to the DHMP member resources section of the DHMP website for easily accessible health information and relevant tools.
- Implement a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To follow up on recommendations related to the FY 2021–2022 CAHPS, DHMP reported engaging in the following QI initiatives:

- Continued to improve communication with clinics about health plan QI initiatives, including education about health plan CAHPS scores.
- Increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Shared information with the newly formed DHHA Access to Care Committee regarding members who were unable to schedule a timely visit with their primary or specialty care provider. This committee is charged with improving access to care at DHHA and utilizes these data to make necessary changes to availability of appointments at DHHA.
- Implemented focused member outreach and care management to facilitate care transitions when acuity of need is identified.
- Increased types of appointments (SBHCs, eye exams, mammograms) that can be scheduled using MyChart.

- Revamped the DHMP member resources section of the DHMP website. The new version makes it easier for members to find important information about plan benefits, preventive care, access to care, care and follow up of important chronic conditions, and help with basic needs (food, utilities, etc.).
- Converted all CAHPS production activities into Smartsheet for a more streamlined and organized process between the CAHPS vendor and DHMP internal staff members.

Assessment of DHMP's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that DHMP addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with DHMP.

QOC Grievances and Concerns Audit

Findings

In CY 2022, DHMP reported no potential QOC grievances or concerns investigated during CY 2022. DHMP's average CHP+ membership in CY 2022 was 4,276, with 2,962 members enrolled as of December 31, 2022. Since there were no records to review, HSAG was unable to determine if DHMP adhered to its policies and procedures for handling QOC grievances and concerns.

DHMP: Strengths

DHMP submitted various policies and procedures outlining how DHMP handles QOC grievances and concerns; however, HSAG was unable to determine strengths related to DHMP's QOC grievance and concern processes since no cases were reported during CY 2022.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- Policies and procedures submitted did not include definitions, detailed descriptions of processes, or who is responsible for carrying out the processes briefly mentioned in the documents (such as reporting to committees or the Department).
- Although DHMP had an outcome or findings rating system as stated on the Quality of Care Concern Internal Routing & Intake Form, the form and documents submitted lacked definitions of these categories and did not describe how the ratings were used to determine actions needed or next steps.
- During the DHMP interview, staff members stated how customer service staff members and grievance and appeal staff members are directed to refer member complaints to the QI nurse if the staff member feels that the situation could jeopardize the health, safety, or welfare of members, or

involves violation of company policies and procedures related to member care. However, DHMP did not have written criteria or a checklist to which staff members could refer.

- During the review period, DHMP reported no grievances or QOCs for the CHP+ population.
- Policies and procedures stated that QOC cases may be reported to the Department; however, policies and procedures did not outline the process for reporting QOC grievances and concerns to the Department and regulatory agencies.

To address these opportunities, HSAG recommends DHMP:

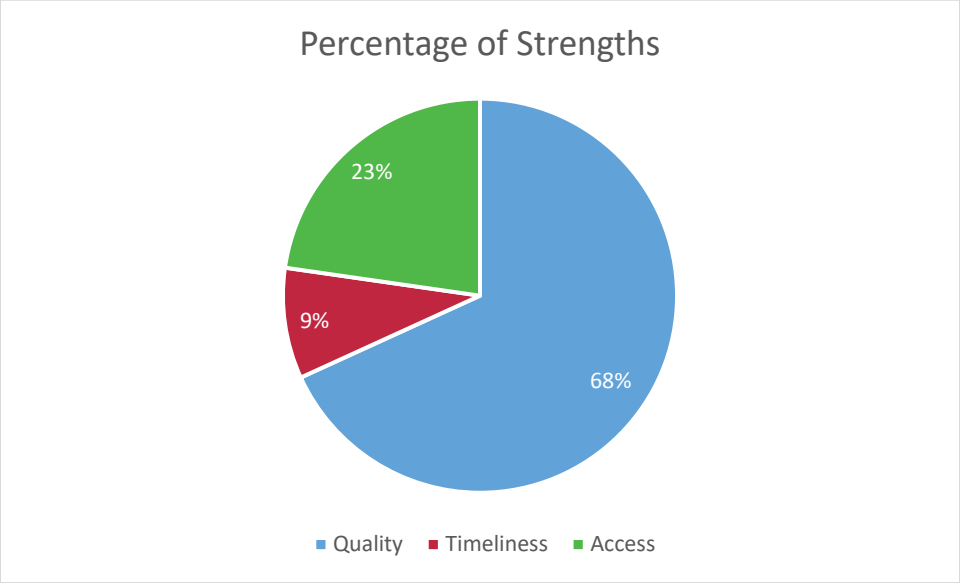
- Review and revise policies as needed to include definitions, and clearly articulate processes and who is responsible for carrying out the processes.
- Review its QOC grievance/concern processes and create a clear policy or cohesive set of documents to describe DHMP's response to QOC grievances and concerns.
- Develop written criteria, checklists, or examples of situations that would indicate a referral to the RN is warranted.
- Perform a comprehensive audit of call center logs to assess how many calls may have included an expression of dissatisfaction and were not processed as a grievance. Furthermore, HSAG strongly recommends that DHMP develop a working relationship with the DHHA patient advocate team and QI team to better understand the events and complaints that occur within the DHHA hospital and clinic system. Additionally, HSAG recommends that DHMP develop a comprehensive QOC grievance/concern training program for all staff that may have a role in identifying, submitting for review, or investigating QOC grievances and concerns.
- DHMP may want to consider clarifying policies and procedures with regard to reporting QOC grievances and concerns to regulatory agencies and working with the Department to determine which regulatory agencies should receive reporting of QOC grievances and concerns and under what circumstances. HSAG also recommends that DHMP more clearly define in policies and procedures the circumstances under which QOC investigations are reported to the Department and at what point in the investigation.

Follow-Up on FY 2021–2022 Recommendations

The QOC Grievances and Concerns Audit was not conducted for CHP+ MCEs in FY 2021–2022.

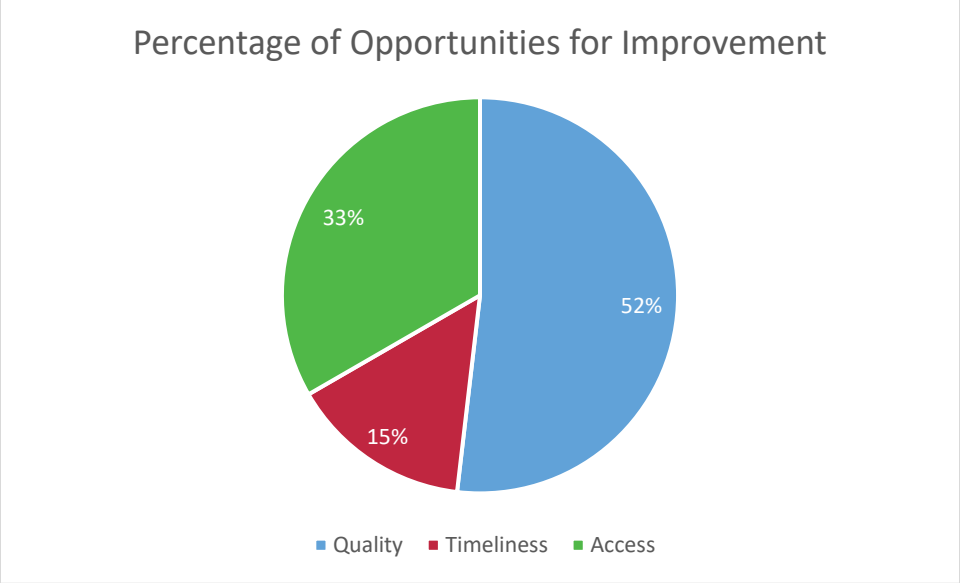
Kaiser Permanente Colorado

Figure 4-5—Percentage of Strengths by Care Domain for Kaiser*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 4-6—Percentage of Opportunities for Improvement by Care Domain for Kaiser*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are Kaiser's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, Kaiser continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, Kaiser established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process: Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021, and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-21 and Table 4-22 summarize Kaiser's PIP activities that were completed and validated in FY 2020–2021. Table 4-21 provides the SMART Aim statements that Kaiser defined for the two PIP outcome measures in Module 1.

Table 4-21—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood medical office buildings (MOBs) between ages 12 and 17 years who are screened for depression annually from 14.22% to 25.00%. This will be achieved by utilizing key driver diagram interventions.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members ages 12–17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.

**HSAG approved revisions to the SMART Aim statement in October 2022.*

Table 4-22 summarizes the preliminary key drivers and potential interventions Kaiser identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-22—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Ensure appropriate depression screening questionnaire is administered and recorded in the EHR. • Increase annual well visits among 12- to 17-year-olds.
Potential Interventions	• Text message well-visit reminders. • Include depression screening questionnaire in pre-visit forms on KP.org. • Pre-load depression screening questionnaire in member's EHR profile. • Provide opportunities to complete the depression screening questionnaire in the waiting room and during the well-visit exam, if not previously completed.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Ensure behavioral medicine specialists are available to meet with member at the time of the positive depression screen. • Results of depression screening questionnaire are recorded in the EHR. • Provide medication support to PCPs via integrated e-consult system with child psychiatry.
Potential Interventions	• Enlist an on-site licensed clinical social worker to provide BH support to the provider and member at the time of positive depression screen. • Ensure the PCP uses the e-consult system for guidance from the child psychiatrist on BH medication options.

Table 4-23 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-23—Intervention Testing Plan for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Provide member with a link to an electronic depression screening form (PHQ-2/PHQ-9) via secure email when well visit appointment is scheduled and request that member completes form prior to attending appointment	No evidence of depression screening questionnaire being provided to the member	Ensure Pre-Teen/Teen Questionnaire (containing PHQ-2/PHQ-9) is administered and recorded in the EHR	Percentage of CHP+ members 12–17 years of age who attend a well visit at Westminster or Englewood MOBs and who were screened for clinical depression as part of the well visit, as documented in the EHR

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Provide member with an electronic tablet to complete the depression screening form (PHQ-2/PHQ-9) at appointment check-in, with screening responses captured directly in the EHR from tablet	No evidence of depression screening questionnaire being provided to the member	Ensure Pre-Teen/Teen Questionnaire (containing PHQ-2/PHQ-9) is administered and recorded in the EHR	Percentage of CHP+ members 12–17 years of age who attend a well visit at Westminster or Englewood MOBs and who were screened for clinical depression as part of the well visit, as documented in the EHR

FY 2022–2023 PIP Activities

In FY 2022–2023, Kaiser continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

HSAG analyzed Kaiser's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated Kaiser's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for Kaiser's PIP are presented in Table 4-24. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-24—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of all CHP+ members assigned to Westminster and Englewood medical office buildings (MOBs) between ages 12 and 17 years who are screened for depression annually.	14.22%	25.00%	29.69%	Yes
Follow-Up After a Positive Depression Screen				
The 30-day follow-up rate for all CHP+ members ages 12–17 years who screen positive for depression.	100%	90% or greater	100%	*Not applicable*

To guide the project, Kaiser established goals of increasing the percentage of members 12 through 17 years of age who receive a depression screening during a well visit at the Englewood and Westminster MOBs from 14.22 percent to 25.00 percent and maintaining the percentage of those members who receive BH services within 30 days of screening positive for depression at 90 percent or higher through the SMART Aim end date of June 30, 2022. Kaiser's reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 29.69 percent, representing a statistically significant increase of 15.47 percentage points above the baseline rate. Because Kaiser's baseline performance rate on the *Follow-Up After a Positive Depression Screen* measure was 100 percent, it was not possible for the PIP to demonstrate statistically significant improvement in this measure; however, the SMART Aim measure results showed that the health plan maintained the 100 percent follow-up rate throughout the project.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, Kaiser completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-25 summarizes Kaiser's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-25—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Auto-assign the depression screening questionnaire at the time the well visit is scheduled and provide the member with a link to complete the depression screening form (PHQ-2/PHQ-9) electronically via secure email when the well visit appointment is scheduled and request that the member complete the form prior to attending the appointment.	Significant *programmatic* and *clinical* improvement for *Depression Screening*	Adopted
Provide the member with an electronic tablet to complete the depression screening form (PHQ-2/PHQ-9) at appointment check-in, with screening responses captured directly in the electronic health record (EHR) from the tablet.	Significant *programmatic* improvement for *Depression Screening*	Adopted
Update the after-visit summary for members who screen positive for depression to provide additional, easily accessible provider contact information and resources for obtaining virtual or in-person BH follow-up services.	Improvement in *Follow-Up After a Positive Depression Screen* was not applicable because there was no room for improvement in the measure	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

Kaiser: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for Kaiser:

- Kaiser developed and carried out a methodologically sound improvement project.
- Kaiser accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results for *Depression Screening* demonstrated achievement of the SMART Aim measure and statistically significant improvement over baseline performance.
- The reported SMART Aim measure results for *Follow-Up After a Positive Depression Screen* demonstrated that Kaiser achieved the SMART Aim goal and maintained a follow-up rate of 100 percent throughout the project.
- Kaiser's intervention testing results demonstrated clinically and programmatically significant improvement in *Depression Screening* linked to the tested interventions.

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

Based on PIP validation activities conducted in FY 2022–2023, Kaiser's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of Kaiser's PIP, HSAG recommended Kaiser:

- Collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- Ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, develop and document a plan for sustaining the improvement beyond the end of the project.

- At the end of the project, synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Assessment of Kaiser's Approach to Addressing FY 2021–2022 PIP Recommendations

Kaiser successfully addressed HSAG's FY 2021–2022 recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2022 FAR, Kaiser was fully compliant with all IS standards relevant to the scope of the PMV performed by Kaiser's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted Kaiser's performance measure reporting.

Performance Measure Results

Table 4-26 shows the performance measure results for Kaiser for MY 2020 through MY 2022, along with the percentile rankings for each MY 2021 rate.

Table 4-26—Performance Measure Results for Kaiser

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	30.45%	48.51%	46.98%	10th–24th
Ages 12 to 17 Years[H]	30.45%	41.81%	40.83%	10th–24th
Ages 18 to 21 Years[H]	41.16%	30.16%	26.69%	50th–74th
Total[H]	34.60%	44.27%	42.70%	10th–24th
Childhood Immunization Status				
DTaP[H]	71.25%	78.90%	71.88%	50th–74th
IPV[H]	85.63%	92.66%	85.42%	25th–49th
MMR[H]	86.25%	89.91%	84.38%	50th–74th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
HiB[H]	87.50%	91.74%	84.38%	50th–74th
Hepatitis B[H]	85.00%	94.50%	88.54%	50th–74th
VZV[H]	84.38%	88.99%	85.42%	50th–74th
Hepatitis A[H]	83.75%	90.83%	86.46%	75th–89th
Pneumococcal Conjugate[H]	80.63%	84.40%	78.13%	75th–89th
Rotavirus[H]	78.13%	78.90%	72.92%	50th–74th
Influenza[H]	62.50%	72.48%	60.42%	75th–89th
Combination 3[H]	67.50%	77.06%	67.71%	50th–74th
Combination 7[H]	63.75%	69.72%	60.42%	75th–89th
Combination 10[H]	49.38%	56.88%	47.92%	75th–89th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	45.83%	47.12%	38.61%	10th–24th
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	—	35.21%	BTSA
2 Years[SA]	—	—	77.08%	BTSA
3 Years[SA]	—	—	65.09%	BTSA
Total[SA]	—	—	61.54%	BTSA
Immunizations for Adolescents				
Meningococcal[H]	87.50%	81.02%	80.28%	25th–49th
Tdap[H]	91.55%	87.35%	85.21%	50th–74th
HPV[H]	61.15%	43.67%	44.37%	75th–89th
Combination 1 (Meningococcal, Tdap)[H]	85.81%	80.12%	79.58%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)[H]	59.46%	42.47%	43.31%	75th–89th
Lead Screening in Children				
Lead Screening in Children[H]	—	—	2.08%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	93.78%	91.40%	90.55%	≥90th
BMI Percentile—Ages 12 to 17 Years[H]	93.14%	89.91%	90.57%	≥90th
BMI Percentile—Total[H]	93.52%	90.75%	90.56%	≥90th
Counseling for Nutrition—Ages 3 to 11 Years[H]	89.32%	93.60%	91.11%	≥90th
Counseling for Nutrition—Ages 12 to 17 Years[H]	89.28%	91.70%	91.74%	≥90th
Counseling for Nutrition—Total[H]	89.31%	92.77%	91.40%	≥90th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	89.32%	93.88%	91.44%	≥90th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	89.28%	92.14%	92.13%	≥90th
Counseling for Physical Activity—Total[H]	89.31%	93.12%	91.75%	≥90th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	51.35%	16.67%	23.61%	<10th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	61.18%	47.55%	64.20%^	25th–49th
Behavioral Health Care				
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	NA	37.14%	54.84%	≥90th
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Total[H]	NA	NA	NA	—
Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Cholesterol Testing—Total[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	NA	NA	NA	—
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[H]	—	—	1.00%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	NA	NA	—

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Total[H]	—	NA	NA	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	—	17.62%	BTSA
LARC—Ages 15 to 20 Years[SA]	—	—	4.13%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—3 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
LARC—90 Days—Ages 15 to 20 Years[SA]	—	—	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	—	NA	70.21%	<10th
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	NA	NA	—
Ages 12 to 18 Years[H]	—	NA	NA	—
Total (Ages 5 to 18 Years)[SA]	—	91.18%	80.00%	BTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	97.06%	—	NA	—
Use of Services				
Ambulatory Care: Emergency Department Visit*				
<1 Year[SA]	—	—	576.00	BTSA
Ages 1 to 9 Years[SA]	—	—	291.92	BTSA
Ages 10 to 19 Years[SA]	—	—	173.79	BTSA
Total (Ages 0 to 19 Years)[H]	—	—	228.53	BTSA

** For this indicator, a lower rate indicates better performance.*

— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.

[SA] indicates that the measure could only be compared to the statewide average.

BTSA indicates the reported rate was better than the statewide average.

Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.

Kaiser: Strengths

The following HEDIS MY 2022 measure rates were determined to be high-performing rates for Kaiser (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2021; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2021):

- *Childhood Immunization Status—Combination 7* and *Combination 10*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS MY 2022 measure rates were determined to be low-performing rates for Kaiser (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2021):

- *Child and Adolescent Well-Care Visits—Total*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Lead Screening in Children*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

To address these low rates, HSAG recommends Kaiser:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS Measure Recommendations

FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG recommended Kaiser:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommended Kaiser coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[4-5]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[4-6]
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of Kaiser's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

Based on the recommendations provided by HSAG, Kaiser reported implementing the following:

- Created a new Well Visit Workgroup that implemented a new outreach campaign for members and care gap reminders for providers.

Kaiser provided limited information on activities in place to address the FY 2021–2022 HEDIS measure recommendations. Although Kaiser indicated a new Well Visit Workgroup was established and had implemented member outreach engagement activities, HSAG was not able to extract the details of the types of outreach campaigns conducted (i.e., telephonic, text messaging, media etc.), frequency of gap lists, and whether the gap lists were focused on timely well-care visits and who was conducting the outreach (i.e., provider, the plan, etc.). Lastly, the reported approach to addressing the FY 2021–2022 HEDIS measure recommendations did not capture efforts in place to improve vaccination compliance or target outreach efforts across measures where timely follow-up occurs.

4-5 The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Dec 12, 2023.

4-6 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 12, 2023.

Assessment of Compliance With CHIP Managed Care Regulations

Kaiser Overall Evaluation

Table 4-27 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2022–2023.

Table 4-27—Summary of Kaiser Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	34	30	4	0	0	88%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	31	31	22	9	0	0	71%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**72**	**13**	**0**	**0**	**85%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Table 4-28 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2022–2023.

Table 4-28—Summary of Kaiser Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	68	68	65	3	0	96%
Grievances	27	27	27	0	0	100%
Appeals	5	5	5	0	0	100%
Totals	**100**	**100**	**97**	**3**	**0**	**97%***

**The overall record review score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Kaiser: Trended Performance for Compliance With Regulations

Table 4-29 displays Kaiser's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 4-29—Compliance With Regulations Trended Performance for Kaiser

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020, 2022–2023)	**68%**	**88%**
Standard II—Adequate Capacity and Availability of Services (2016–2017, 2019–2020, 2022–2023)	**100%**	**100%**
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	80%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	88%	60%
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	90%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021, 2022–2023)	**70%**	**71%**
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	87%	100%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	89%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*****	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**For all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***In FY 2017–2018 all CHP+ health plans received a score of "NA" for the Subcontractual Relationships and Delegation standard. All requirements within this standard were new as of the 2016 managed care revisions, yet CHP+ health plans were not required to comply until FY 2018–2019.*

****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, Kaiser demonstrated consistently moderate- to high-achieving scores for three standards. Standard VI—Grievance and Appeal Systems improved by 1 percentage point compared to the previous review cycle; Standard I—Coverage and Authorization of Services improved by 20 percentage points; and Standard II—Adequate Capacity and Availability of Services maintained 100 percent compliance, indicating a general to strong understanding of most federal and State regulations.

Kaiser: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG identified the following strengths for Kaiser:

- Kaiser had well-documented mechanisms in place to ensure consistent application of review criteria for authorization decisions and described an IRR process that met the testing threshold of 90 percent during the most current review process.
- NABD letters included member rights and NABD, grievance, and appeal letters were written in an easily understood level and format, at or around the sixth-grade reading level.
- Staff members described an increased focus on member access to PCP appointments during the review period, culminating in adding 20 percent capacity, moving providers from 50 percent to 70 percent availability for new members, and adding daily appointment slots for adults and children (16 to 20 and 19 to 22 daily appointments, respectively).
- Staff members described how female members had the right to direct access to a women's healthcare specialist, which was shared with members through the member handbook, referred to by Kaiser as the Evidence of Coverage and operationalized internally as evidenced in the Self-Referral to Specialty Reference Sheet. Extended appointment hours on weekdays and weekend appointments were available, and Kaiser offered member services call centers, telehealth services, nurse advice lines, BH access, and PH appointments.
- Kaiser consistently met the standard and expedited time frames for providing grievance and appeal oral and written acknowledgement and resolution notices to members. Kaiser also had well-documented processes to ensure that individuals who made decisions on grievances and appeals were not involved in any previous level of review.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to Kaiser's system with no restriction.

Kaiser: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- Not all federal and State requirements were included in its policies and procedures.
- The member handbook stated the limits for speech, occupational, and physical therapy visits are 30 therapy visits per year combined.
- Quarterly NAV reports, annual reports, and other network monitoring reports demonstrated that Kaiser's network access did not consistently adhere to time and distance standards in Douglas County.

- Documentation did not consistently specify how the call centers and clinical staff operationalized to meet timely access to care and service standards for BH within policies, procedures, or other evidence.
- During the interview, staff members were not able to provide an overview of the Kaiser CHP+ population, subgroups, and any identified trends in cultural attitudes, values, customers, or beliefs that could affect access to or benefits from healthcare services or risks associated with the member population.
- The time frame to submit a Network Changes and Deficiencies Report to the Department was not included within any policies or procedures.
- In some instances, policies and procedures specified the incorrect time frame for acknowledgement and resolution notices to members.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Update its policies, procedures, and the member handbook to ensure that all federal and State-specific requirements related to coverage and authorization of services are included.
- Update its member handbook to align with the Colorado Revised Statutes, Section 10-16-104, that allow for 20 visits for each therapy type.
- Seek opportunities to expand the care network in Douglas County to ensure adequate network providers and member access to care according to the minimum time and distance standards.
- Further detail BH timely access standards by phone, in person, and outpatient follow-up appointments after discharge from hospitalization.
- Expand mechanisms to monitor and identify CHP+ populations that may benefit from outreach, education, and specialized access related to cultural needs.
- Update internal documents to outline how Kaiser will meet the five-day Network Deficiencies Reporting timeline.
- Review and update its policies, procedures, and member handbooks to specify calendar or working days in all time frames referenced in the documents.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- Develop or update its historical policy to be inclusive of all member rights.

Assessment of Kaiser's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, Kaiser updated its policy to include all member rights and informed other staff members of the policy updates. HSAG recognizes that the policy updates and training are not

likely to result in any significant improvements as Kaiser already had other ways of effectively communicating member rights and training staff members; however, by updating the policy and incorporating it into the routine review and update cycle, Kaiser is likely to maintain long-term compliance.

Validation of Network Adequacy

Kaiser: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for Kaiser:

- Kaiser met all minimum network requirements for Adult, Family, and Pediatric Primary Care Practitioners (MD, DO, NP, CNS), Gynecology, OB/GYN (MD, DO, NP, CNS), General and Pediatric Behavioral Health Practitioners, and General and Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.
- Kaiser demonstrated strength in the General Specialist category, meeting the minimum network requirements for all contracted counties except General Endocrinology and General Pulmonary Medicine.
- Overall, 88.3 percent of Kaiser's sampled providers were found in the online provider directory and at the sampled location.
- Kaiser had match rates above 90 percent for all 10 PDV indicators.

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

HSAG found the following opportunities for improvement:

- Kaiser did not meet the minimum network requirements for Adult, Family, and Pediatric Primary Care Practitioners (PA), Pharmacies, Acute Care Hospitals, Psychiatric Hospitals, Psychiatric Units in Acute Care Hospitals, Pediatric Pulmonary Medicine, and Gynecology, OB/GYN (PA) for more than 50 percent of the contracted counties.
- Based on the PDV results, opportunities for improvement were not identified for Kaiser.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Continue to conduct an in-depth review of provider categories for which Kaiser did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies, including a root cause analysis to identify the discrepancy in providers listed in the Kaiser data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that Kaiser seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of Kaiser's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, Kaiser reported taking the following actions:

- For Pharmacies, Acute Care Hospitals, and Pediatric Specialties, Kaiser follows CMS guidelines when it comes to network adequacy requirements, which for geoaccess is 90 percent in Large Metro and Metro counties. All of these areas are measuring above 90 percent in all counties and, in most cases, are measuring above 96 percent. Kaiser recommends aligning the CHP+ contract with the CMS requirement.
- For Psychiatric Hospitals/Psychiatric Units, Douglas County is currently not meeting geoaccess network adequacy requirements. Castle Rock is the affected area where members are not within the drive distance of an Inpatient Psychiatric Provider. Kaiser has a Letter of Agreement (LOA) with Highlands Behavioral Health in Littleton (which is within the driving distance of Castle Rock), which offers Inpatient Psychiatric care, but since it is an LOA, Kaiser is unable to list it in the provider directory or use it for network adequacy measurements. This LOA is available for adolescent and adult CHP+ members to utilize when necessary. Besides this facility, it appears that there are no additional Inpatient Psychiatric facilities in that area with which Kaiser could pursue a contract.

Based on the above response, Kaiser has worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

CAHPS Survey

Findings

Table 4-30 shows the results achieved by Kaiser for FY 2020–2021 through FY 2022–2023.

Table 4-30—Top-Box Scores for Kaiser

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	65.2%	60.6%	66.7%
Rating of All Health Care	70.9%	68.3%	70.1%
Rating of Personal Doctor	76.9%	78.0%	75.9%
Rating of Specialist Seen Most Often	78.8%+	69.4%+	71.7%+
Getting Needed Care	78.7%	79.7%+	79.4%
Getting Care Quickly	88.1%+	80.4%+	84.1%
How Well Doctors Communicate	95.3%	97.8%	93.5% ▼
Customer Service	83.6%+	85.2%+	84.7%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*

↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*

▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*

▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

Kaiser: Strengths

The following measures' FY 2022–2023 scores for Kaiser were higher, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

The following measure's FY 2022–2023 score for Kaiser was statistically significantly lower than the FY 2021–2022 score:

- *How Well Doctors Communicate*

To address this low CAHPS score, HSAG recommends Kaiser implement appropriate interventions to improve the performance related to the care members need through the following, as applicable:

- Conduct root cause analyses or focus studies and obtain feedback from parents/caretakers on their child's recent office visit through a follow-up call or email to determine what could be driving parents'/caretakers' lower perceptions of the quality of the care and services their child member received.
- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with child members and their parents/caretakers.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To follow up on recommendations related to the FY 2021–2022 CAHPS, Kaiser reported engaging in the following QI initiatives:

- Continued focus on improving access to primary and specialty care and enhancing virtual care options.
- Made improvements to the onboarding process to better engage CHP+ members.

Assessment of Kaiser's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that Kaiser addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with Kaiser.

QOC Grievances and Concerns Audit

Findings

In CY 2022, Kaiser investigated two potential QOC grievance cases. Kaiser's average CHP+ membership in CY 2022 was 7,510, with 5,312 members enrolled as of December 31, 2022. Of the two cases investigated by Kaiser, neither case was substantiated.

Kaiser: Strengths

Based on QOC Grievances and Concerns Audit activities in FY 2022–2023, HSAG found the following strengths for Kaiser:

- Within the two cases reviewed, HSAG found that professionals (i.e., nurses and physicians) reviewed the QOC concern cases submitted to Kaiser.
- Kaiser investigated, analyzed, tracked, trended, and closed QOC concern investigations according to stated policies and procedures for the two cases reviewed. HSAG determined that Kaiser adhered to its internal policies and procedures.
- Policies, procedures, flow charts, and training tools adequately described a process whereby an RN/Quality Review Coordinator (QRC) and/or physician/peer review committee, investigates, analyzes, tracks, trends, and determines actions or follow-up needed in response to QOC concerns. Review of the two records demonstrated that Kaiser followed the stated processes.
- HSAG identified the following best practices within Kaiser's processes:
  - Kaiser provided a checklist for the grievance and appeal staff members to use to identify which complaints warrant referral to a QRC for review to determine if further investigation is warranted.
  - Kaiser provided a checklist for QRCs to use to determine if referral to a physician reviewer is warranted.
  - Kaiser used clear and well-developed training materials to train QRCs, physicians, and peer reviewers involved in the review of potential QOC concerns.
  - When closing a case, Kaiser physician reviewers use a two-factor score to assign two scores to each case, which determines next steps.
  - Kaiser completed reporting and tracking potential QOC concerns using integrated software systems.

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

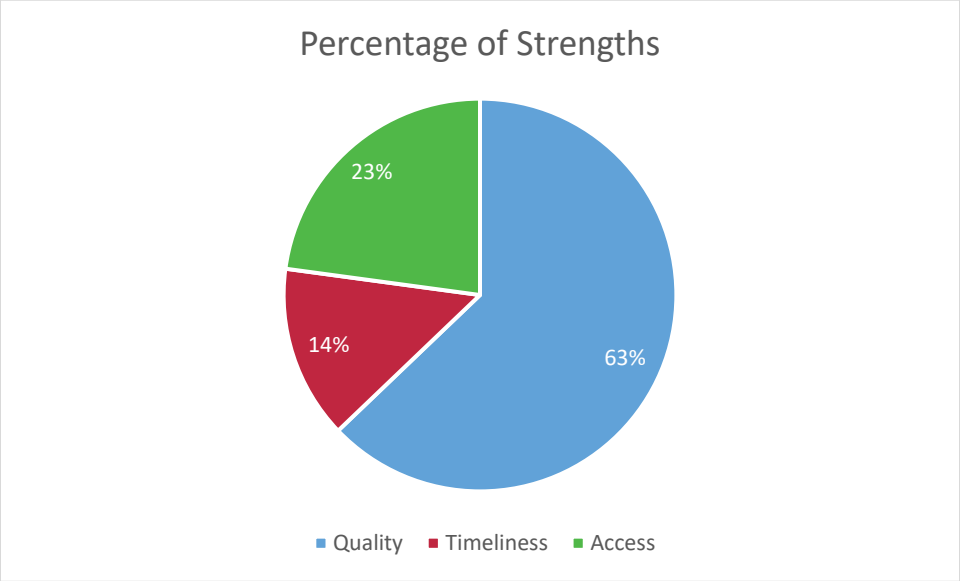
HSAG found that Kaiser did not have any opportunities for improvement that lead to recommendations during the case review period. However, Kaiser may want to consider collaborating with the Department to develop a case-specific reporting model for more serious QOC grievances and concerns. Additionally, Kaiser may also want to consider working with the Department to determine if additional regulatory agencies should receive reporting of QOC grievance and concern investigations and under what circumstances.

Follow-Up on FY 2021–2022 Recommendations

The QOC Grievances and Concerns Audit was not conducted for CHP+ MCEs in FY 2021–2022.

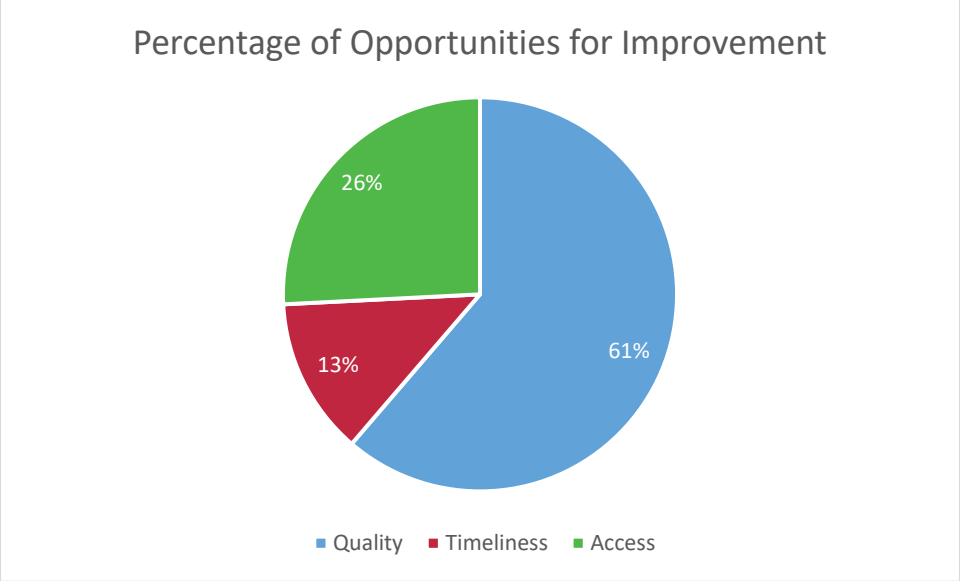
Rocky Mountain Health Plans

Figure 4-7—Percentage of Strengths by Care Domain for RMHP*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 4-8—Percentage of Opportunities for Improvement by Care Domain for RMHP*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are RMHP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, RMHP established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process: Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021, and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-31 and Table 4-32 summarize RMHP's PIP activities that were completed and validated in FY 2020–2021. Table 4-31 provides the SMART Aim statements that RMHP defined for the two PIP outcome measures in Module 1.

Table 4-31—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP members 12 years of age or older from 2.0% to 25.0%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP members 12 years of age or older who screen positive for depression that are successfully connected to appropriate BH services within 30 days to the established benchmark of 46.89%.

**The SMART Aim statement was revised in January 2023. HSAG approved revisions to the SMART Aim statement in January 2023 in response to RMHP's correction of data queries used to produce the baseline percentage.*

Table 4-32 summarizes the preliminary key drivers and potential interventions RMHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 4-32—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Established workflow for depression screening during office visits. • Established workflow for depression screening during telehealth visits. • Provider awareness and understanding of appropriate depression screening coding practices.
Potential Interventions	• Implement provider and office staff education on depression screening workflow for office visits. • Establish a workflow for depression screening during telehealth visits. • Implement provider training on depression screening scoring, documentation, and reporting.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Established workflow for patient follow-up care following a positive depression screen. • Defined process for appropriate BH intervention when a patient screens positive for depression. • Referral and scheduling of follow-up visit in response to positive depression screen. • Appropriate billing practices for follow-up services.
Potential Interventions	• Establish processes and workflows to define appropriate care when a patient screens positive for depression. • Guidance from BH providers and staff members on appropriate provider involvement when a patient screens positive for depression. • Develop standardized workflow for follow-up service billing and integration of CPT codes. • Track members who screen positive for depression and are in need of follow-up behavioral services.

Table 4-33 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-33—Intervention Testing Plan for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Develop, implement, and train medical assistants (MAs) and providers on a new workflow to score, document, and correctly code depression screens with a negative result (G8510) and positive result (G8431)	• MA does not calculate score and submit to superbill • PHQ-2/PHQ-9 is scored and billed incorrectly	• Provider, care team, and billing/coding education regarding proper coding of positive and negative depression screen for CHP+	• Percentage of depression screenings completed for CHP+ members by Mountain Family Health Centers (MFHC) for which a negative depression screen coded G8510 was submitted for billing • Percentage of depression screenings completed for CHP+ members by MFHC for which a positive depression screen coded G8431 was submitted for billing
Develop and deploy a registry for patients who score positive on PHQ-9 to guide behavioral health advocates (BHAs) to connect to patients for BH follow-up when appropriate	• Patient has a positive PHQ-9, but PHQ-9 report does not accurately capture all patients • Community BH providers not accepting new patients • Patient does not prioritize BH visit as part of medical services	• Implement PHQ strategy for follow-up interaction with patients who screen positive for depression	• Percentage of CHP+ members with a positive depression screen coded G8431, referred to BH services using the PHQ-9 report, who scheduled a follow-up visit with BHA within 30 days of positive screen
Same-day warm hand-off and consultation with a behavioral health clinician (BHC) when member screens positive for depression and BHC follow-up with member/caregiver to ensure BH follow-up visit	• Community BH providers do not schedule within 30 days or communicate referral status to Pediatric Partners of the Southwest (PPSW) • Community BH providers not accepting	• Define process for appropriate BH intervention when a patient screens positive for depression	• Percentage of CHP+ members who were referred by PPSW to a community BH provider for a positive depression screen coded (G8431) and who have referral marked as "complete"

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
is scheduled and completed within 30 days	new patients per payer or age demographic • Patient may not be ready to engage in therapy for depression		within 30 days of positive screen
Develop, implement, and train providers on new workflow to score, document, and correctly code for depression screen with a negative result (G8510) or positive result (G8431)	• No process exists in data system to block incorrect depression screening codes (96160, 96161) • No process exists to replace incorrect depression screening codes (96160, 96161) with correct codes (G8510, G8431)	• Provider and care team use of correct codes for positive and negative depression screening results for CHP+ and Medicaid members/patients	• Percentage of CHP+ members screened for depression with a negative depression screen coded (G8510) and submitted to RMHP • Percentage of CHP+ members screened for depression with a positive depression screen coded (G8431) and submitted to RMHP

FY 2022–2023 PIP Activities

In FY 2022–2023, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed the initial Module 4 submission form, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

HSAG analyzed RMHP's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated RMHP's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for RMHP's PIP are presented in Table 4-34. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-34—SMART Aim Measure Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings for RMHP CHP+ members 12 years of age and older who received care at MFHC or PPSW.	2.0%	25.0%	24.78%	*Yes*
Follow-Up After a Positive Depression Screen				
The percentage of RMHP CHP+ members 12 years of age and older who screen positive for depression at MFHC or PPSW that are successfully connected to the appropriate BH services within 30 days.	100%*	46.89%	50.00%	*Not Applicable*

* The baseline percentage was based on a denominator size of "1." Due to the extremely low baseline denominator size, the Department and HSAG approved a SMART Aim goal based on an established benchmark rather than a goal representing statistically significant improvement.

To guide the project, RMHP established goals of increasing the percentage of members 12 years of age and older who receive a depression screening from 2.0 percent to 25.0 percent and ensuring 46.89 percent or greater of those members receive BH services within 30 days of screening positive for depression, through the SMART Aim end date of June 30, 2022. RMHP's reported SMART Aim measure results for *Depression Screening* demonstrated that the highest rate achieved, 24.78 percent, was a statistically significant increase of 22.78 percentage points above the baseline rate but fell just short of achieving the goal. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 50.00 percent, exceeded the goal; however, it was not possible to achieve statistically significant improvement over the baseline percentage of 100 percent.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, RMHP completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-35 summarizes RMHP's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-35—Intervention Testing Results for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
MFHC Intervention 1: Develop, implement, and train MAs and providers on a new workflow to score, document, and accurately code depression screens with a negative result (G8510) and positive result (G8431).	Significant *programmatic* improvement for *Depression Screening*	Adopted
PPSW Intervention 1: Develop, implement, and train providers on new workflow to score, document, and correctly code for depression screen with a negative result (G8510) or positive result (G8431).	Significant *programmatic* improvement for *Depression Screening*	Adopted
MFHC Intervention 2: Develop and deploy a registry for patients who score positive on the Patient Health Questionnaire (PHQ-9) to guide BHAs to connect to patients for BH follow-up when appropriate.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
PPSW Intervention 2: Same-day warm handoff and consultation with a BHC when a member screens positive for depression and BHC follow-up with member/caregiver to ensure BH follow-up visit is scheduled and completed within 30 days.	Significant *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

Validation Status

Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*.

RMHP: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP developed and carried out a methodologically sound improvement project.
- RMHP accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated achievement of statistically significant improvement over baseline performance for the *Depression Screening* measure and achievement of the SMART Aim goal for the *Follow-Up After a Positive Depression Screen* measure.

- RMHP's intervention testing results demonstrated programmatically significant improvement for both measures and clinically significant improvement for *Follow-Up After a Positive Depression Screen* linked to the tested interventions. 

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

Based on PIP validation activities conducted in FY 2022–2023, RMHP's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of RMHP's PIP, HSAG recommended RMHP:

- Collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- Ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Assessment of RMHP's Approach to Addressing FY 2021–2022 PIP Recommendations

RMHP successfully addressed HSAG's FY 2021–2022 recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2022 FAR, RMHP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted RMHP's performance measure reporting.

Performance Measure Results

Table 4-36 shows the performance measure results for RMHP for MY 2020 through MY 2022, along with the percentile rankings for each MY 2022 rate.

Table 4-36—Performance Measure Results for RMHP

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years[H]	45.15%	56.45%	**51.14%^^**	25th–49th
Ages 12 to 17 Years[H]	32.37%	46.44%	46.15%	25th–49th
Ages 18 to 21 Years[H]	54.59%	30.69%	**21.83%^^**	25th–49th
Total[H]	45.15%	50.84%	**47.14%^^**	25th–49th
Childhood Immunization Status				
DTaP[H]	64.76%	54.86%	70.55%^	50th–74th
IPV[H]	74.89%	66.29%	81.51%^	10th–24th
MMR[H]	80.62%	75.43%	83.56%^	25th–49th
HiB[H]	74.89%	70.29%	82.19%^	25th–49th
Hepatitis B[H]	75.33%	68.00%	80.14%^	10th–24th
VZV[H]	76.21%	74.86%	84.93%^	50th–74th
Hepatitis A[H]	81.94%	71.43%	78.08%	25th–49th
Pneumococcal Conjugate[H]	69.16%	60.57%	73.97%^	50th–74th
Rotavirus[H]	64.32%	62.86%	73.97%^	75th–89th
Influenza[H]	55.07%	56.57%	45.89%	25th–49th
Combination 3[H]	59.47%	52.00%	64.38%^	50th–74th
Combination 7[H]	53.74%	49.14%	61.64%^	75th–89th
Combination 10[H]	41.85%	42.86%	37.67%	50th–74th
Chlamydia Screening in Women				
Ages 16 to 20 Years[H]	30.77%	35.05%	32.12%	<10th
Developmental Screening in the First Three Years of Life				
1 Year[SA]	—	66.21%	63.33%	BTSA

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
2 Years[SA]	—	64.80%	65.73%	BTSA
3 Years[SA]	—	48.87%	51.58%	BTSA
Total[SA]	—	57.54%	58.87%	BTSA
Immunizations for Adolescents				
Meningococcal[H]	67.37%	70.02%	**62.24%^^**	<10th
Tdap[H]	82.34%	82.77%	85.13%	25th–49th
HPV[H]	33.53%	36.69%	**26.54%^^**	<10th
Combination 1 (Meningococcal, Tdap)[H]	63.47%	68.90%	**61.33%^^**	<10th
Combination 2 (Meningococcal, Tdap, HPV)[H]	28.44%	33.11%	**22.43%^^**	<10th
Lead Screening in Children				
Lead Screening in Children[H]	—	—	35.37%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Ages 3 to 11 Years[H]	13.59%	17.32%	19.72%^	<10th
BMI Percentile—Ages 12 to 17 Years[H]	13.68%	19.13%	21.21%^	<10th
BMI Percentile—Total[H]	13.63%	18.06%	20.36%^	<10th
Counseling for Nutrition—Ages 3 to 11 Years[H]	26.94%	30.42%	25.84%^	<10th
Counseling for Nutrition—Ages 12 to 17 Years[H]	22.47%	22.68%	21.73%^	<10th
Counseling for Nutrition—Total[H]	25.20%	27.26%	24.06%^	<10th
Counseling for Physical Activity—Ages 3 to 11 Years[H]	6.51%	13.59%	18.01%^	<10th
Counseling for Physical Activity—Ages 12 to 17 Years[H]	6.53%	15.22%	19.17%^	<10th
Counseling for Physical Activity—Total[H]	6.52%	14.26%	18.52%^	<10th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[H]	22.69%	26.79%	41.18%^	10th–24th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits[H]	75.24%	71.43%	70.00%	50th–74th
Behavioral Health Care				
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 13 to 17 Years[H]	—	—	NA	—
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	—	NA	—

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17 Years[H]	—	35.48%	NA	—
30-Day Follow-Up—Ages 6 to 17 Years[H]	—	58.06%	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase[H]	51.22%	40.91%	41.86%	50th–74th
Continuation and Maintenance Phase[H]	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose Testing—Total[H]	NA	NA	NA	—
Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Cholesterol Testing—Total[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years[H]	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total[H]	NA	NA	NA	—
Screening for Depression and Follow-Up Plan				
Ages 12 to 17 Years[H]	—	6.81%	9.17%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Ages 1 to 11 Years[H]	—	NA	NA	—
Ages 12 to 17 Years[H]	—	NA	NA	—
Total[H]	—	NA	NA	—
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—Ages 15 to 20 Years[SA]	—	24.39%	20.88%	BTSA
LARC—Ages 15 to 20 Years[SA]	—	5.49%	4.52%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—3 Days—Ages 15 to 20 Years[SA]	—	NA	NA	—
MMEC—90 Days—Ages 15 to 20 Years[SA]	—	NA	NA	—
LARC—3 Days—Ages 15 to 20 Years[SA]	—	NA	NA	—
LARC—90 Days—Ages 15 to 20 Years[SA]	—	NA	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[H]	—	NA	38.10%	<10th

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Ages 5 to 11 Years[H]	—	NA	NA	—
Ages 12 to 18 Years[H]	—	NA	NA	—
Total (Ages 5 to 18 Years)[SA]	—	82.50%	77.78%	BTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years[H]	77.00%	—	81.16%	75th–89th
Use of Services				
Ambulatory Care: Emergency Department Visit *				
<1 Year[SA]	—	12.73	540.25	BTSA
Ages 1 to 9 Years[SA]	—	15.10	210.32	BTSA
Ages 10 to 19 Years[SA]	—	30.63	195.47	BTSA
Total (Ages 0 to 19 Years)[SA]	—	14.34	209.36	BTSA

** For this indicator, a lower rate indicates better performance.*

— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.

[SA] indicates that the measure could only be compared to the statewide average.

BTSA indicates the reported rate was better than the statewide average.

Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2021 to MY 2022.

Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2021 to MY 2022.

RMHP: Strengths

The following HEDIS MY 2022 measure rates were determined to be high-performing rates for RMHP (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2021; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2021):

- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 7*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS MY 2022 measure rates were determined to be low-performing rates for RMHP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2021):

- *Child and Adolescent Well-Care Visits—Total*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Immunizations for Adolescents—Combination 1* and *Combination 2*
- *Lead Screening in Children*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

To address these low rates, HSAG recommends RMHP:

- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. The MCOs should also consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives.
- Consider increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the state.
- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Follow-Up on FY 2021–2022 HEDIS Measure Recommendations

FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG recommended RMHP:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommended RMHP coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[4-7]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[4-8]
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

Assessment of RMHP's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

Based on the recommendations provided by HSAG, RMHP reported implementing the following:

- A monthly dashboard was created to monitor, track, and trend performance measures.
- A behavioral health incentive payouts (BHIP) expansion project kicked off in the fall of 2022 and launched in early 2023 by incentivizing PCMPs and independent provider network (IPN) providers for being open to referrals and completing encounters in the time frame for the measures.
- For the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures, RMHP implemented the following interventions:
  - Distributed annual wellness visit reminders along with education on the importance of annual wellness visits.
  - Created a workgroup that focused interventions for the pediatric population.
  - Created a social media campaign for annual wellness visits.
  - Conducted an annual audit to ensure data was captured correctly.
  - Submitted welcome guides to new members to provide education and recommendations regarding the importance of wellness visits.
  - Conducted welcome calls to new enrollees including warm transfer to primary care for appointment to provide education and promote annual well visits.

4-7 The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Dec 12, 2023.

4-8 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 12, 2023.

- For the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, RMHP implemented the following interventions:
  - Distributed a postpartum care incentive and educational mailing brochure.
  - Created a workgroup that focused interventions for the maternity and women's care population.
  - Partnered with WellHop and SimpliFed to offer exclusive programs to its members. Through these programs, expectant moms could receive additional support during their pregnancies, postpartum, and with breastfeeding, pumping, formula feeding, or a combination.
- For the *Chlamydia Screening in Women* measure, RMHP implemented the following interventions:
  - Distributed a women's health member email brochure that included a women's annual care checklist and recommended preventive screenings.
  - Created a workgroup that focused on interventions for the maternity and women's care population.
  - Posted educational materials to the provider portal.
  - Created a social media campaign for various screenings.
- For the *Cervical Cancer Screening* measure, RMHP implemented the following interventions:
  - Distributed a women's health member email brochure that included a women's annual care checklist and recommended preventive screenings.
  - Created a workgroup that focused on interventions for the maternity and women's care population.
- For the *Asthma Medication Ratio* measure, RMHP implemented the following interventions:
  - Created a workgroup that focused on interventions for the diabetic and chronic conditions population.
  - Posted educational materials to the provider portal.
- For the *Asthma in Younger Adults Admission Rate* measure, RMHP implemented the following interventions:
  - Created a workgroup that focused on interventions for the diabetic and chronic conditions population.
  - Posted educational materials to the provider portal.
- For the *Childhood Immunization Status* measure, RMHP implemented the following interventions:
  - Distributed new baby packets that included education regarding child safety, recommended immunizations by age 2, and promoted children's health and safety through routine well-child checks.
  - Distributed a two-year immunization mailing brochure incentive to members' parents/guardians at age 18 months; members' parents/guardians are eligible to receive a gift card upon completion and after showing proof of receiving all recommended immunizations by their child's second birthday.
  - Created a social media campaign for various immunizations.

- For the *Immunizations for Adolescents* measure, RMHP implemented the following interventions:
  - Distributed monthly postcards for adolescents who missed an immunization between ages 16 to 18 years.
  - Created a workgroup that focused interventions for the pediatric population.
  - Created a social media campaign for various immunizations.
- For the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, RMHP implemented the following interventions:
  - Created a workgroup that focused interventions for the pediatric population.
  - Distributed an educational flyer on follow-up care for children prescribed ADHD medication for providers.
- For the *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit* measures, RMHP implemented the following interventions:
  - Integrated BH into many primary care practices to assist with transitions of care after hospitalizations and increase access.
  - Expanded the BH IPN to increase access to BH services and assist with transitions of care.
  - RMHP had a doctorate level integrated behavioral health advisor who assisted practices with BH workflows and implementation of best practices across RMHP's service area.

RMHP reported strong member-, provider-, and community-facing interventions targeted to improve the QOC and timely access to healthcare services. HSAG recommends evaluating the effectiveness of the interventions and the observed impact the interventions have on performance rates. This includes but is not limited to evaluating the percentage of members who received mailers and incentives that resulted in a rendered service. Lastly, based on the effectiveness of the intervention, determine the sustainability and spread plan to target other service types that may benefit from these types of interventions.

Assessment of Compliance With CHIP Managed Care Regulations

RMHP Overall Evaluation

Table 4-37 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2022–2023.

Table 4-37—Summary of RMHP Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	34	33	1	0	0	97%

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
II. Adequate Capacity and Availability of Services	14	14	13	1	0	0	93%
VI. Grievance and Appeal Systems	31	31	29	2	0	0	94%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**81**	**4**	**0**	**0**	**95%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Table 4-38 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2022–2023.

Table 4-38—Summary of RMHP Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	68	61	7	32	90%
Grievances	60	50	50	0	10	100%
Appeals	60	55	54	1	5	98%
Totals	**220**	**173**	**165**	**8**	**47**	**95%***

**The overall record review score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

RMHP: Trended Performance for Compliance With Regulations

Table 4-39 displays RMHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 4-39—Compliance With Regulations Trended Performance for RMHP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020, 2022–2023)	**91%**	**97%**
Standard II—Adequate Capacity and Availability of Services (2016–2017, 2019–2020, 2022–2023)	**100%**	**93%**

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	80%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	88%	100%
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021, 2022–2023)	**97%**	**94%**
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	93%	94%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	83%	100%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA*****	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**For all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***In FY 2017–2018 all CHP+ health plans received a score of "NA" for the Subcontractual Relationships and Delegation standard. All requirements within this standard were new as of the 2016 managed care revisions, yet CHP+ health plans were not required to comply until FY 2018–2019.*

****NA indicates the first year of reviewing the standard.*

In FY 2022–2023, RMHP demonstrated a consistently high-achieving score or improvement from the previous review year for Standard I—Coverage and Authorization of Services. Two standards declined compared to the previous review year; Standard II—Adequate Capacity and Availability of Services declined by 7 percentage points, and Standard VI—Grievance and Appeal Systems declined by 3 percentage points. However, each standard scored above 90 percent, indicating a strong understanding of most federal and State regulations.

RMHP: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG identified the following strengths for RMHP:

- Documentation within the denial samples demonstrated extensive outreach to the provider when additional information or clarification is needed. Most files included at least two outreaches and some files included 10 or more documented efforts. Some NABDs included clear recommendations

for the member to obtain the recommended alternative LOC and listed available providers in the area, including contact information.

- RMHP accurately defined "emergency services" and "poststablilization" in accordance with federal and State requirements. The claims production manager described how these service codes are set up in the claims system to pass through or be immediately approved upon the manual review process. Monitoring included annual review of trends with pended claims and internal audits.
- Staff members described ongoing efforts to continue expanding the RMHP network, which includes seeking Behavioral Health Administration funding whenever possible. Leadership noted a significant network gain with the provider, Integrated Insights Therapy, that serves the Delta, Gunnison, and Montrose regions. RMHP provided support to this provider in order to scale and grow into new offices in western Montrose.
- RMHP's cultural competency trainings, outreach, and initiatives located in documentation and described by staff members were extensive and specifically targeted to its membership. Staff members discussed a focus on SDOH and increasing assessments.
- RMHP has a system in place to receive, log, and track a grievance request from the member at any time. RMHP submitted a sample of 10 grievances that met 100 percent compliance for readability and timeliness of acknowledgment and resolution letters.
- Although the time frame to accept appeals from the member is 60 calendar days, RMHP reported accepting appeals beyond the 60-calendar-day window, under certain circumstances. Staff members reported during the interview that if the member needed a service, they would assist the member in filing an appeal or start a new request for the alternative LOC recommended in the NABD.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to RMHP's system with no restriction.

RMHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- Some NABDs reviewed included acronyms or clinical terminology that could be explained in a more member-friendly manner.
- Information regarding the CYMHTA was not included in templates at the time of the audit.
- In some instances within the denial samples, the denial was issued prior to the end of the authorization review period.
- Some language related to authorization timelines in the UM Program Description did not clarify that the time frame starts at the time of the request.

- Seven denial sample files incorrectly included references to paying for benefits continued during an appeal or State fair hearing under the section "Understanding The Results Of Your Appeal, Quick Appeal, Or State Review."
- The Standards for Practitioner Office Sites policy incorrectly stated the time frames for urgent and non-urgent care visits, and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits.
- The CHP+ Member Handbook stated that if the member calls with an appeal request, RMHP will send a letter that must be signed by the member and returned in order to confirm that RMHP understands the verbal request. Additionally, RMHP's UM Program Description incorrectly stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider.
- RMHP's Appeals Policy and Procedure did not specify that the right to request benefits/services continue while the State fair hearing is pending and how to make the request does not apply to CHP+ members.

To address these opportunities for improvement, HSAG recommends RMHP:

- Conduct additional internal review and plain language explanations whenever possible.
- Conduct occasional quality assurance verification procedures to ensure that templates are aligned with the correct LOB.
- Consider using the full allotted timeline for making authorization decisions and to use extensions if it is in the best interest of the member.
- Update its language related to authorization timelines in the UM Program Description to clarify that the time frame starts at the time of the request.
- Revise its CHP+ NABD template to remove all references to continuation of benefits.
- Update the Standards for Practitioner Office Sites policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and include the exceptions related to when well-care visits should be scheduled prior to one month.
- Update the CHP+ Member Handbook and UM Program Description to remove any references that require a member to submit appeal information in writing.
- Update its Appeals Policy and Procedure to specify that continuation of benefits is not applicable to CHP+ members.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- Send follow-up letters to members as a best practice after outreach calls from care coordinators, notifying members of the information and resources available to them.

- Conduct annual monitoring to ensure that providers are not denied based on discriminatory reasons.

Assessment of RMHP's Approach to Addressing FY 2021–2022 Compliance Recommendations

HSAG identified no required actions; therefore, there was no CAP required.

Validation of Network Adequacy

RMHP: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for RMHP:

- RMHP met all minimum network requirements for Pediatric and Family Practitioners (MD, DO, NP, CNS), Pediatric Behavioral Health Practitioners, Pharmacies, Pediatric Psychiatrists and other Psychiatric Prescribers, and Pediatric SUD Treatment Practitioners across all contracted counties.
- RMHP had match rates above 90 percent for all 10 PDV indicators.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

HSAG found the following opportunities for improvement:

- RMHP did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for any of its contracted counties. Gynecology, OB/GYN (PA), Pediatric Endocrinology, and Pediatric Neurology did not meet the minimum network requirements for more 50 percent of the contracted counties.
- Overall, 19.7 percent of RMHP's providers could not be located in the online provider directory. Of the providers located in the provider directory, only 75.9 percent were found at the sampled location.

To address these opportunities for improvement, HSAG recommends RMHP:

- Continue to conduct an in-depth review of provider categories for which RMHP did not meet the time and distance contract standards, with the goal of determining whether or not the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- Review the case-level data files containing mismatched information between its provider data and its online provider directory and address data deficiencies, including a root cause analysis to identify the discrepancy in providers listed in the RMHP data that could not be located in the online provider directory.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that RMHP seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of RMHP's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, RMHP reported taking the following actions:

- RMHP maintained an open network policy for all providers within its service areas who met its credentialing and quality standards. Given the rural and frontier nature of its service area, there were few new entrants into the region recently, but RMHP has been able to add a small number of new providers. Most notably, RMHP recently added a NP staff member in an endocrinology practice in Mesa County, which is a net gain in access.
- RMHP has continued to expand its pilot project for e-consults, which provides PCP access to specialist consultations with providers outside their immediate area, and in some areas outside RMHP service area.

Based on the above response, RMHP worked to address the NAV recommendations from FY 2021–2022. and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

CAHPS Survey

Findings

Table 4-40 shows the results achieved by RMHP for FY 2020–2021 through FY 2022–2023.

Table 4-40—Top-Box Scores for RMHP

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Health Plan	70.2%	70.7%	67.9%
Rating of All Health Care	74.3%	66.5%	68.1%
Rating of Personal Doctor	74.1%	73.4%	71.8% ↓

Measure	FY 2020–2021 Score	FY 2021–2022 Score	FY 2022–2023 Score
Rating of Specialist Seen Most Often	73.8%+	76.9%+	76.7%+
Getting Needed Care	85.1%	88.7%	87.2%
Getting Care Quickly	89.6%	93.4%	91.5% ↑
How Well Doctors Communicate	97.5%	95.5%	96.7% ↑
Customer Service	89.4%+	89.8%+	86.7%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.
↑ *Indicates the FY 2022–2023 score is statistically significantly higher than the 2022 NCQA national average.*
↓ *Indicates the FY 2022–2023 score is statistically significantly lower than the 2022 NCQA national average.*
▲ *Indicates the FY 2022–2023 score is statistically significantly higher than the FY 2021–2022 score.*
▼ *Indicates the FY 2022–2023 score is statistically significantly lower than the FY 2021–2022 score.*

RMHP: Strengths

The following measures' FY 2022–2023 scores for RMHP were statistically significantly higher than the 2022 NCQA national averages:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

The following measures' FY 2022–2023 scores for RMHP were higher, although not statistically significantly, than the FY 2021–2022 scores:

- *Rating of All Health Care*
- *How Well Doctors Communicate*

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

The following measure's FY 2022–2023 score for RMHP was statistically significantly lower than the 2022 NCQA national average:

- *Rating of Personal Doctor*

To address this low CAHPS score, HSAG recommends RMHP implement appropriate interventions to improve the performance related to the care members need through the following, as applicable:

- Conduct root cause analyses or focus studies and obtain feedback from parents/caretakers on their child's recent office visit through a follow-up call or email to determine what could be driving

parents'/caretakers' lower perceptions of the quality of the care and services their child member received.

- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Include information about the ratings from the CAHPS survey and emphasize patient-centered communication in provider communications throughout the year.
- Publish brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with child members and their parents/caretakers.

Follow-Up on FY 2021–2022 CAHPS Recommendations

FY 2021–2022 CAHPS Recommendations

To follow up on recommendations related to the FY 2021–2022 CAHPS, RMHP reported engaging in the following QI initiatives:

- Implemented a process within customer service to notify Provider Relations and the Value Based Contracting Review Committee (VBCRC) when they are informed by members that a healthcare provider is not accepting new patients or are requiring applications for acceptance. Provider Relations follows up with the provider to investigate and address members' concerns. Additionally, this is tracked by the VBCRC to evaluate objectively if the practices are meeting the openness to Medicaid and CHP+ requirements based on their value-based contracts.
- During member welcome calls, customer service educates members on the importance of having a primary care relationship with a PCP. Customer Service asks members if they have a PCP and if they have an appointment coming up. If they do not have a PCP, Customer Service offers to help the member find one and connect them with the office to schedule an appointment.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, more in the last year. This included member mailers and emails, adding quick response (QR) codes to existing mailers, and business cards for care coordinators and external stakeholders to distribute with CirrusMD for information.
- Included member experience topics in newsletter articles, learning collaborative events, and webinar series. Topics included leadership training, BH skills training, and care management training.
- Provided cultural competency training to providers at health equity training, care management training, and BH skills training.
- Expanded the eConsult program in Mesa County. The goal of this program is for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc. This eConsult project supports general satisfaction with providers because it may reduce referrals to specialists with long wait times, empowers the primary care practice, and increases education/clinical pathways within primary care.

Assessment of RMHP's Approach to Addressing FY 2021–2022 CAHPS Recommendations

HSAG has determined that RMHP addressed the prior year's recommendations and that these QI initiatives may lead to improved CAHPS scores and overall member experiences with RMHP.

QOC Grievances and Concerns Audit

Findings

In CY 2022, RMHP investigated four potential QOC grievance/concern cases. RMHP's average CHP+ membership in CY 2022 was 9,052, with 7,122 members enrolled as of December 31, 2022. Of the four cases investigated by RMHP, no cases were substantiated.

RMHP: Strengths

Based on QOC Grievances and Concerns Audit activities in FY 2022–2023, HSAG found the following strengths for RMHP:

- Within the four cases reviewed, HSAG found that professionals (i.e., nurses, clinical analysts, and a medical director) reviewed the QOC concern cases submitted to RMHP, which followed RMHP's outlined policies and processes.
- Based on review of the cases submitted, RMHP investigated, analyzed, tracked, trended, and closed QOC concern investigations according to stated policies and procedures.
- RMHP's policies included reporting to Colorado Department of Regulatory Agencies if unethical or patient safety issues exist and to the Department upon request. None of the four cases reviewed warranted reporting to regulatory agencies. However, RMHP staff members reported that RMHP delivers a monthly report to the Department that includes QOC grievance or concern cases that have been closed out.
- The RMHP CHP+ Member Handbook and the MCE's website included information for the member about QOC concerns and filing a grievance if the member has a QOC concern. The handbook defined "quality of care" as when the "health care services you received meet medical standards and are likely to improve your health." HSAG identified this as a best practice for RMHP.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- RMHP's Quality Improvement Program Description stated that staff members receiving a grievance or appeal are directed to forward suspected QOC issues to "the appropriate department"; however, neither policy included a definition of QOC issue, QOC concern, or QOC grievance.

- Policies and other documents submitted did not describe use of a rating scale for assessing the severity of QOC grievance and concern cases reviewed by RMHP, the meanings of the various levels, or how the levels assigned determine next steps. Cases reviewed indicated RMHP assigned the cases a severity rating of "no issue."
- None of the four cases reviewed warranted reporting to regulatory agencies; however, RMHP may want to consider working with the Department to determine if additional regulatory agencies should receive reporting of QOC grievance and concern investigations and under what circumstances.

To address these opportunities, HSAG recommends RMHP:

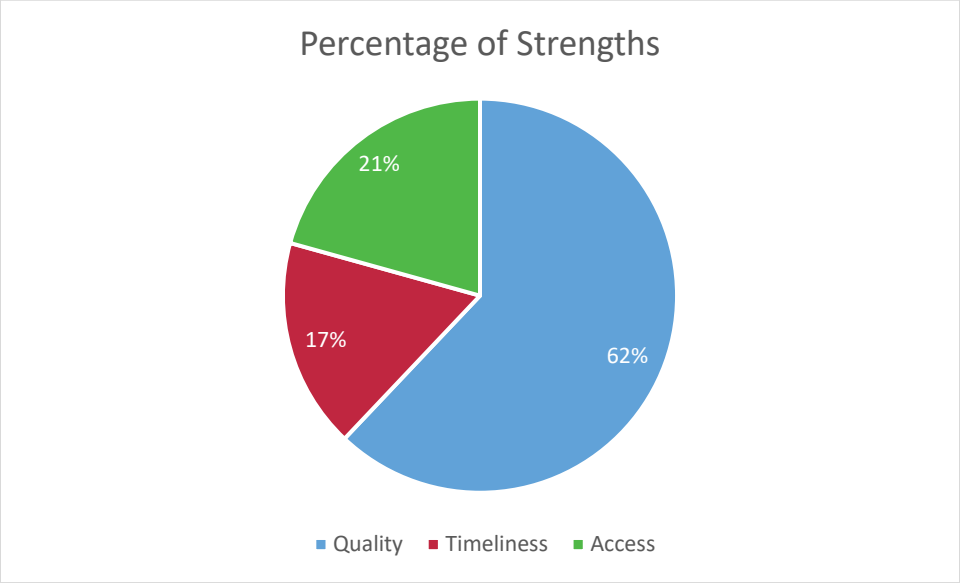
- Develop checklists or tools with criteria for grievance/appeal staff members or customer services staff members to identify which complaints warrant referral to the QI case review team for review to determine if further investigation is warranted.
- Consider developing a workflow to assist with determining which policies related to QOC concerns may need additional detail.
- Develop a training for all staff who may identify QOC issues or concerns, and who review and investigate the potential QOC grievances or concern. Additionally, RMHP should develop tools for nonclinical staff to determine if further review of complaints is warranted and enhance and clarify policies and procedures relating to assigning severity levels.

Follow-Up on FY 2021–2022 Recommendations

The QOC Grievances and Concerns Audit was not conducted for CHP+ MCEs in FY 2021–2022.

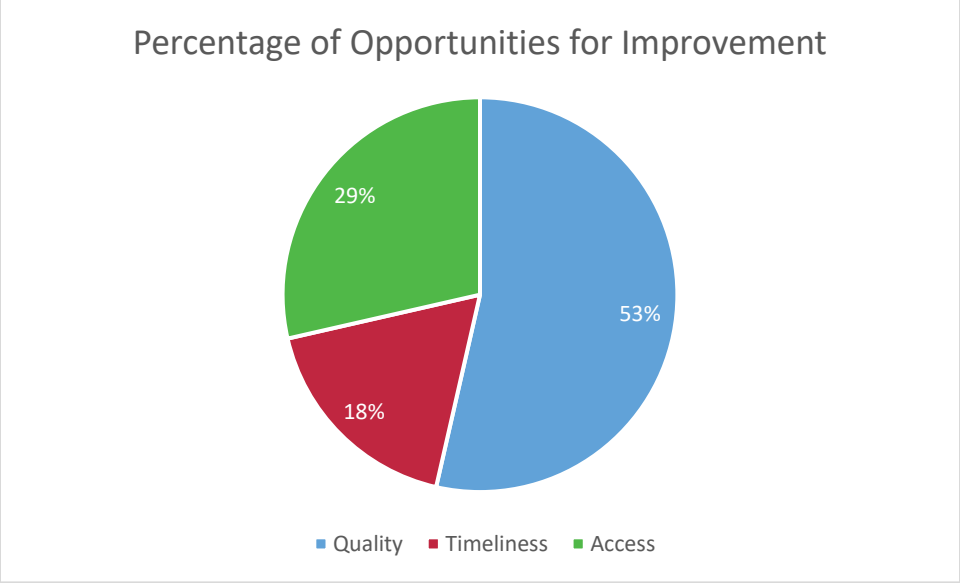
DentaQuest

Figure 4-9—Percentage of Strengths by Care Domain for DentaQuest*



**Each strength may impact one or more domains of care (quality, timeliness, or access).*

Figure 4-10—Percentage of Opportunities for Improvement by Care Domain for DentaQuest*



**Each recommendation may impact one or more domains of care (quality, timeliness, or access).*

Following are DentaQuest's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality, timeliness, and accessibility of care and services.

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2022–2023, DentaQuest continued the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP, which was initiated in FY 2020–2021. While the FY 2022–2023 PIP validation activities focused on Module 4—PIP Conclusions, DentaQuest established a foundation for the project by completing the first three modules of HSAG's rapid-cycle PIP process: Module 1—PIP Initiation and Module 2—Intervention Determination in FY 2020–2021, and Module 3—Intervention Testing in FY 2021–2022. A summary of the previous year's PIP activities is provided below to provide background and context for the FY 2022–2023 Module 4 PIP validation findings.

Background: FY 2020–2021 and FY 2021–2022 PIP Activities

Table 4-41 and Table 4-42 summarize DentaQuest's PIP activities that were completed and validated in FY 2020–2021. Table 4-41 provides the SMART Aim statement that DentaQuest defined for the PIP outcome measure in Module 1.

Table 4-41—SMART Aim Statement for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Dental Service Utilization Among 3–5-Year-Olds Residing in Weld County	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members aged 3–5 who reside in Weld County, from 45.47% to 49.30%.

Table 4-42 summarizes the preliminary key drivers and potential interventions DentaQuest identified to facilitate progress toward the SMART Aim goal in Module 2.

Table 4-42—Preliminary Key Drivers and Potential Interventions for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Preliminary Key Drivers	• Awareness of dental benefits. • Access to dental services. • Provider participation to encourage benefit utilization. • Caregiver understanding of the importance of oral health in primary teeth.
Potential Interventions	• Provide outreach and education to member/caregiver on dental benefits and the importance of early oral health. • Collaborate with community partners to distribute dental benefit information. • Partner with network dental providers to offer non-traditional modes of dental care. • Document and distribute information on flexible dental provider office hours. • Notify member's assigned dental provider if no dental service has been received in the past 12 months. • Implement a dental home care model for Colorado CHP+ members. • Partner with schools to engage children and parents in oral health and prevention.

Table 4-43 summarizes the interventions and intervention effectiveness measures identified for the Plan component of the PDSA cycle in Module 3.

Table 4-43—Intervention Testing Plan for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Free online provider training on preventing early childhood dental caries, with continuing education credits, offered to general and pediatric dentists in Weld County	• Parent/Guardian of member does not receive reinforcing education on importance of care on primary teeth	• Parent/Guardian understanding of the importance of oral health in primary teeth	• Percentage of general and pediatric dentists in Weld County who were notified of the availability of the "ECC [Early Childhood Caries] Management for the General Dentist" online training and who completed the training
Outreach with incentive offered to members and their caregivers to seek dental services by	• Parent/Guardian of member does not open/does not receive educational packet on	• Parent/Guardian understanding of the importance of oral health in primary teeth	• Percentage of eligible members who were successfully reached for a direct call offering the

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
offering appointment scheduling assistance and a backpack with age-appropriate oral health materials for completing the visit	dental benefits and importance of preventive care on primary (baby) teeth		incentive for completing a dental visit • Percentage of members ages 3–5 years who reside in Weld County and have not received a dental visit in the previous 18 months who completed a dental visit during the intervention period

FY 2022–2023 PIP Activities

In FY 2022–2023, DentaQuest continued the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process during FY 2022–2023. HSAG reviewed initial Module 4 submission forms, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission forms.

HSAG analyzed DentaQuest's PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated DentaQuest's success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for DentaQuest's PIP are presented in Table 4-44. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 4-44—SMART Aim Measure Results for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
The percentage of members who received any dental service among members ages 3–5 years who reside in Weld County.	45.47%	49.30%	59.86%	Yes

To guide the project, DentaQuest established a goal to increase the percentage of members 3 to 5 years of age in Weld County who received any dental service from 45.47 percent to 49.30 percent by the SMART Aim end date of June 30, 2022. At the conclusion of the project, DentaQuest's reported SMART Aim

measure results demonstrated that the goal was exceeded, with the highest rate achieved, 59.86 percent, representing a statistically significant increase of 14.39 percentage points above the baseline rate.

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, DentaQuest completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 4-45 summarizes DentaQuest's interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 4-45—Intervention Testing Results for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Free online provider training on preventing early childhood dental caries, with continuing education credits, offered to dentists in Weld County	No improvement	Abandoned
Outreach with incentive offered to members and their caregivers to seek dental services by offering appointment scheduling assistance and a backpack with age-appropriate oral health materials for completing the visit	Significant *clinical* improvement	Adapted

Validation Status

Based on the validation findings, HSAG assigned the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP a level of *High Confidence*.

DentaQuest: Strengths

Based on PIP validation activities conducted in FY 2022–2023, HSAG found the following strengths for DentaQuest:

- DentaQuest developed and carried out a methodologically sound improvement project.
- DentaQuest accurately reported SMART Aim measure and intervention testing results.
- The reported SMART Aim measure results demonstrated achievement of the SMART Aim goal and statistically significant improvement over baseline performance.

- DentaQuest's intervention testing results demonstrated clinically significant improvement in dental utilization among children ages 3 to 5 years residing in Weld County linked to the tested interventions.

DentaQuest: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

Based on PIP validation activities conducted in FY 2022–2023, DentaQuest's final Module 4 submission met all validation criteria, and HSAG did not identify any opportunities for improvement.

Follow-Up on FY 2021–2022 PIP Recommendations

FY 2021–2022 PIP Recommendations

To support successful progression of DentaQuest's PIP, HSAG recommended DentaQuest:

- Collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- Ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the health plan should document which interventions had the greatest impact.

Assessment of DentaQuest's Approach to Addressing FY 2021–2022 PIP Recommendations

DentaQuest successfully addressed HSAG's FY 2021–2022 recommendations for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP from the previous fiscal year by documenting evidence of the following in the FY 2022–2023 PIP submission:

- Complete and accurate effectiveness evaluation results for each intervention.
- Use of consistent and comparable data collection methodology for calculating SMART Aim measure results over time for the duration of the PIP.
- A plan for sustaining improvement achieved through the PIP beyond the end of the project.
- Lessons learned during the PIP that can be applied in future improvement activities.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2022 FAR, DentaQuest was fully compliant with all IS standards relevant to the scope of the PMV performed by the PAHP's LO's auditor. During review of the IS standards, the auditor identified no issues that impacted DentaQuest's performance measure reporting.

Performance Measure Results

Table 4-46 shows the performance measure results for DentaQuest for MY 2020 through MY 2022, along with the percentile rankings for each MY 2022 rate.

Table 4-46—Performance Measure Results for DentaQuest

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Dental and Oral Health Services				
Oral Evaluation, Dental Services				
<1 Year	—	—	3.85%	—
1–2 Years	—	—	24.60%	—
3–5 Years	—	—	38.64%	—
6–7 Years	—	—	44.73%	—
8–9 Years	—	—	45.51%	—
10–11 Years	—	—	43.72%	—
12–14 Years	—	—	41.78%	—
15–18 Years	—	—	32.58%	—
19–20 Years	—	—	22.83%	—
Total	—	—	38.25%	—
Sealant Receipt on Permanent First Molars				
At Least One Sealant	—	24.49%	43.06%	—
All Four Molars Sealed by the 10th Birthdate	—	14.30%	29.27%	—
Topical Fluoride for Children				
Dental Services—1–2 Years	—	—	21.39%	—
Dental Services—3–5 Years	—	—	26.41%	—
Dental Services—6–7 Years	—	—	28.90%	—
Dental Services—8–9 Years	—	—	30.16%	—
Dental Services—10–11 Years	—	—	28.06%	—
Dental Services—12–14 Years	—	—	24.04%	—
Dental Services—15–18 Years	—	—	17.67%	—

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	Benchmark Ranking
Dental Services—19–20 Years	—	—	7.14%	—
Dental Services—Total	—	—	24.19%	—

— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate there was no benchmark for comparison.

DentaQuest: Strengths

The following MY 2022 measure rates were determined to be first year reported rates with no established benchmarks available to compare:

- *Oral Evaluation, Dental Services—Total*
- *Topical Fluoride for Children—Dental Services—Total*

The following MY 2022 measure rates demonstrated improvement relative to prior year, however, due to no established benchmarks, HSAG was unable to compare:

- *Sealant Receipt on Permanent First Molars—At Least One Sealant* and *All Four Molars Sealed by the 10th Birthdate*

DentaQuest: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

For first year reported measures, HSAG recommends closely monitoring baseline performance and assessing potential interventions based on MY 2023 performance.

Follow-Up on FY 2021–2022 HEDIS Measure Recommendations

FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG did not identify any opportunities for improvement for DentaQuest as they were first year reported measures.

Assessment of DentaQuest's Approach to Addressing FY 2021–2022 HEDIS Measure Recommendations

In FY 2021–2022, HSAG did not identify any opportunities for improvement for DentaQuest as they were first year reported measures. However, HSAG recommends evaluating MY 2023 performance relative to MY 2022 and considering potential interventions to support improvement, where applicable.

Assessment of Compliance With CHIP Managed Care Regulations

DentaQuest Overall Evaluation

Table 4-47 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2022–2023.

Table 4-47—Summary of DentaQuest Scores for the FY 2022–2023 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
I. Coverage and Authorization of Services	17	17	12	2	3	0	71%
II. Adequate Capacity and Availability of Services	12	12	9	3	0	0	75%
VI. Grievance and Appeal Systems	31	31	18	11	2	0	58%
XII. Enrollment and Disenrollment	2	2	2	0	0	0	100%
Totals	**62**	**62**	**41**	**16**	**5**	**0**	**66%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

Table 4-48 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2022–2023.

Table 4-48—Summary of DentaQuest Scores for the FY 2022–2023 Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	65	65	54	11	0	83%
Grievances	51	51	45	6	0	88%
Appeals	55	55	47	8	0	85%
Totals	**171**	**171**	**146**	**25**	**0**	**85%***

**The overall record review score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

DentaQuest: Trended Performance for Compliance With Regulations

Table 4-49 displays DentaQuest's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard. DentaQuest's first review was in FY 2019–2020.

Table 4-49—Compliance With Regulations Trended Performance for DentaQuest

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2019–2020, 2022–2023)	**69%**	**71%**
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	**69%**	**75%**
Standard III—Coordination and Continuity of Care (2021–2022)	NA	40%
Standard IV—Member Rights, Protections, and Confidentiality (2021–2022)	NA	100%
Standard V—Member Information Requirements (2020–2021)	NA	63%
Standard VI—Grievance and Appeal Systems (2019-2020, 2020–2021, 2022–2023)	**74%**	**58%**
Standard VII—Provider Selection and Program Integrity (2020–2021)	NA	87%
Standard VIII—Credentialing and Recredentialing (2021–2022)	NA	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	NA	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2021–2022)	NA	50%
Standard XII—Enrollment and Disenrollment (2022–2023)	**NA****	**100%**

Bold text indicates standards reviewed by HSAG during FY 2022–2023.

**For all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***NA indicates the first year of reviewing the standard.*

In FY 2022–2023, DentaQuest demonstrated moderate scores for three of the four standards. Standard VI—Grievance and Appeal Systems, declined by 16 percentage points compared to the previous review period. Standard I—Coverage and Authorization of Services improved by 2 percentage points, while Standard II—Adequate Capacity and Availability of Services improved by 6 percentage points. DentaQuest met 100 percent compliance for Standard XII—Enrollment and Disenrollment, demonstrating a general understanding of federal and State regulations.

DentaQuest: Strengths

Based on the four standards reviewed in FY 2022–2023, HSAG identified the following strengths for DentaQuest:

- DentaQuest followed policies and procedures that describe processes to ensure that member information, including NABDs, are written to ensure members are easily able to understand the content of the notices and, when requested, are available in alternative formats. Additionally, policies and procedures also indicate that once a service is approved by DentaQuest, it does not deny, reduce, or suspend a previously authorized service.
- DentaQuest implemented annual IRR processes that include staff testing to ensure consistent use of criteria. The IRR testing process provides education and training on review criteria, as needed, to ensure consistent application of criteria. IRR reports submitted by DentaQuest showed results consistently above 96 percent.
- Providers met time and distance standards in the following instances, coming close to its goal of 100 percent compliance with time and distance standards.
- The Dental Participating Practice Agreement, and the August 2022 Colorado Summit newsletter included tips for accessibility and accommodations for members with Ehlers-Danlos syndrome to "ensure these patients have a good experience."
- DentaQuest used a new system, Salesforce, to track grievance and appeal cases. Staff members reported that the system has the capability to track the date and time of receipt, each action taken, and the resolution of the grievance and appeal case. Grievance and appeal supervisors described running daily reports to track the status of cases and to monitor timeliness of acknowledgement and resolution notices.
- Policies and procedures described processes to ensure that member acknowledgement and resolution notices are written in easily understood language. Case file reviews identified that grievance and appeal communications with members were written in easily understood language and were usually written at or around the sixth-grade reading level.
- Staff members described a thorough overview of how the enrollment process begins when the EDI 834 files are received from the Department and are added to DentaQuest's system with no restriction.

DentaQuest: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG found the following opportunities for improvement:

- Policies and procedures did not reflect updated information to include federal and State requirements regarding member rights related to the NABD process; the member's right to submit grievances,

appeals, and request a State fair hearing; and accurate time frames for standard, expedited, and extended authorization decisions.

- The Authorization Review policy and Exhibit P did not include the correct time frames for the Colorado CHP+ standard or expedited authorization determination.
- Policies and procedures related to NABD requirements did not include all required details.
- Staff members described that in some instances, specialty services may be performed at a general dentistry office to meet time and distance standards; however, this was not currently reflected within the geoaccess reporting.
- DentaQuest reported that regional network managers attempt to outreach additional providers to join the provider network; however, there were no single case agreements completed during the review period. In these cases, staff members shared that members may travel longer distances to see an in-network provider.
- The member handbook did not include the member has a right to a second opinion at no cost to the member.
- Network adequacy policies and procedures did not include the timeline details that notification to the Department will be sent "within 10 business days" and the definition of a "significant change," which is "5 percent in a 30 day calendar period."
- DentaQuest's Provider Network Adequacy policy stated that results of monitoring efforts are "documented and presented to the Quality Oversight Committee for review," and the Office Reference Manual (ORM) states that DentaQuest "administers a Quality Improvement Program that includes quarterly quality indicator tracking (i.e., appointment waiting time, access to care, etc.)." However, staff members were not able to describe or produce evidence of such oversight or monitoring through any regular internal reporting, meetings, committees, or results of quarterly provider surveys to indicate that the network is being monitored.
- DentaQuest's CO CHIP Network Analysis did not include accurate time and distance standards for general and pediatric dentists in urban, rural, and frontier counties. Additionally, many rural and frontier counties in the September and December 2022 CO CHIP Network Analysis reports did not have access within time and distance standards. NAV reports from FY 2021–2022 also described low adherence to requirements for oral surgeons and pediatric dentists.
- When asked for specific details regarding cultural competency efforts focused on the Colorado CHP+ population, staff members were not able to describe or submit additional evidence of efforts.
- While the CHP+ PAHP contract in place during the review period included the member's right to continue benefits during the appeal and State fair hearing process, it is the Department's intent to

remove this language in alignment with federal regulations, which no longer require continuation of benefits for CHP+.

- The Member Appeal Form only encourages the member to "attach" supporting documentation and did not clarify that appeals may be filed verbally.
- Staff members stated that member calls that express grievances or complaints, when resolved by the CSR or are resolved during the first call to customer service, may not be included in grievance and appeals tracked in the Salesforce system. This may indicate that the quarterly reports submitted to the State do not include all grievances received through customer service calls.

To address these opportunities for improvement, HSAG recommends DentaQuest:

- Revise policies, procedures, member information, and provider information to include all federal and State requirements.
- Update its policies and procedures to align with the federal and State contract requirements, including adhering to standard and expedited authorization decisions, and as expeditiously as the member's condition requires, and not to exceed 10 calendar days following the receipt of the requested service; and address expedited authorization determinations and ensure that members are provided notice no later than 72 hours after receipt of the request.
- Update policies, procedures, and member-facing documents to describe member rights related to the State fair hearing process, ensure NABDs include all applicable member rights (i.e., access to copies of all documents and correct information regarding appeal acknowledgements, appeal resolutions, expedited requests, and extensions) and the specific circumstances in which DentaQuest must give notice on or before the intended effective date of an adverse benefit determination.
- Continue to work with the Department and the HSAG NAV team to explore how to reflect any additional instances where DentaQuest may meet time and distance standards.
- Increase efforts to proactively fill gaps in the provider network where members do not have access within time and distance standards.
- Add information that the member has a right to a second opinion at no cost to the member in the member handbook.
- Expand internal network adequacy policies and procedures to include the timeline details that notification to the Department will be sent "within 10 business days" and the definition of a significant change, which is "5 percent in a 30 day calendar period."
- Enhance its internal policies, procedures, and monitoring of its network to identify gaps and to assess, act on, and address any ongoing trends related to access to care for all contracted provider types.
- Ensure that ongoing network adequacy reporting adheres to current time and distance standards and increase its efforts to recruit and add orthodontists, oral surgeons, and pediatric dentists in rural and frontier counties to its provider network.
- Enhance its cultural competency program or other related efforts to identify members whose cultural norms and practices may affect their access to dental care. Establish and maintain policies specific to

Colorado CHP+ dental outreach for specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups.

- Remove any references to continuation of benefits during appeal and State fair hearings in the member handbook, Office Reference Manual, and any other materials so that DentaQuest does not misinform members about paying for ongoing services that are not required federally.
- Update the Member Appeal Form to ensure that the member is informed sufficiently in advance of the resolution time frame and has reasonable opportunities to present evidence.
- Develop and implement processes to ensure that all grievances received by customer services, including those categorized as an inquiry, are included in the grievance and appeal system, and tracked, trended, and included in its quarterly reporting to the Department.
- Implement procedures and ongoing monitoring to ensure that grievance and appeal acknowledgement and resolution notices are sent in a timely manner and include accurate information within member communications.

Follow-Up on FY 2021–2022 Compliance Recommendations

FY 2021–2022 Compliance Recommendations

- Develop and implement procedures that meet State requirements for coordinating and delivering care; defining SHCN, and clarifying expectations regarding providers developing treatment plans for members with SHCN.
- Update its website to include the Spanish member handbook.
- Develop an annual review mechanism that monitors to ensure providers are not denied based on discriminatory reasons.
- Review internal procedures for extracting and handling credentialing data to ensure accurate internal and external reporting.
- Enhance its documentation and internal auditing process to ensure that PSV for Drug Enforcement Administration (DEA) certification occurs.
- Develop and implement an ongoing comprehensive Quality Assurance/Performance Improvement (QAPI) program for services it furnishes to its CHP+ members that incorporates PIP activities, performance measure reporting, monitoring of over- and underutilization, assessment of member satisfaction, quality and appropriateness of care furnished to members with SHCN, and other key QAPI elements that are specific to the CHP+ LOB. Additionally, develop a process for evaluating the impact and effectiveness of the QAPI program at least annually that is specific to the CHP+ LOB.
- Develop a policy, procedure, or desk protocol to verify the accuracy and timeliness of claims data, and a process for submitting encounter claims data to the Department.
- Develop a communication and monitoring plan to ensure that member, provider, and utilization management staff messaging, and use of CPGs, are consistent.

Assessment of DentaQuest's Approach to Addressing FY 2021–2022 Compliance Recommendations

As part of the FY 2021–2022 CAP, DentaQuest updated policies and developed a mechanism to monitor care coordination that included identifying members with SNCN to ensure members receive accommodations. Regarding QAPI, DentaQuest updated a workplan that included additional Colorado CHP+ details and reported that key Colorado CHP+ staff members participate in quarterly committee meetings to complete, assess, and trend the outcomes of the QAPI program. HSAG recognizes that the policy updates, monitoring of care coordination, and QAPI discussions are likely to result in long-term improvements.

Validation of Network Adequacy

DentaQuest: Strengths

Based on time and distance analysis and PDV activities conducted in FY 2022–2023, HSAG found the following strengths for DentaQuest:

- While DentaQuest did not meet all minimum network requirements across all counties in each county designation, DentaQuest demonstrated strength in the General Dentists network, with 89 percent of all contracted counties meeting the minimum network requirements. In rural counties, DentaQuest met all minimum network requirements for General Dentists. Additionally, DentaQuest demonstrated strength in the Orthodontists network with 91 percent of all contracted counties meeting the minimum network requirements.
- Overall, 95.4 percent of DentaQuest's sampled providers were found in the online provider directory and at the sampled location.
- DentaQuest had match rates above 90 percent for all 10 PDV indicators.

DentaQuest: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

HSAG found the following opportunities for improvement:

- DentaQuest did not meet the minimum network requirements for Pediatric Dentists in more than 50 percent of the contracted counties.
- Based on the PDV results, opportunities for improvement were not identified for DentaQuest.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends DentaQuest:

- Continue to conduct an in-depth review of provider categories for which DentaQuest did not meet the time and distance contract standards, with the goal of determining whether or not the failure to

meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Follow-Up on FY 2021–2022 NAV Recommendations

FY 2021–2022 NAV Recommendations

HSAG recommended that DentaQuest seek opportunities to expand the care network to ensure adequate network providers and member access according to the minimum time and distance standards.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

Assessment of DentaQuest's Approach to Addressing FY 2021–2022 NAV Recommendations

In response to HSAG's recommendation, DentaQuest reported taking the following actions:

- DentaQuest continued to seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.
- DentaQuest plans to update the Quality Team each quarter with updates regarding access to care and what improvements and efforts are being made to recruit new providers to the network.

Based on the above response, DentaQuest worked to address the NAV recommendations from FY 2021–2022, and HSAG has determined that these activities may lead to improvements in meeting time and distance minimum network requirements and member access to care.

FY 2022–2023 was HSAG's first year conducting a PDV activity for the Department. As such, prior recommendations for the PDV activity were not evaluated.

CAHPS Survey

A CAHPS survey was not conducted for Colorado's dental PAHP, DentaQuest.

QOC Grievances and Concerns Audit

Findings

In CY 2022, DentaQuest investigated three potential QOC grievance cases. DentaQuest's average CHP+ membership in CY 2022 was 48,737, with 46,985 members enrolled as of December 31, 2022. Of the three cases investigated, no cases were substantiated.

DentaQuest: Strengths

Based on QOC Grievances and Concerns Audit activities in FY 2022–2023, HSAG found the following strengths for DentaQuest:

- Within the three cases reviewed, HSAG found that professionals (i.e., a dentist) reviewed each of the QOC concern cases submitted to DentaQuest.
- Based on review of the three cases submitted, HSAG determined that DentaQuest investigated and tracked QOC concern investigations.

DentaQuest: Summary Assessment of Opportunities for Improvement and Recommendations Related to the QOC Grievances and Concerns Audit

HSAG found the following opportunities for improvement:

- DentaQuest's policies and procedures submitted did not include definitions, detailed descriptions of processes, or who is responsible for carrying out the QOC processes briefly mentioned in the documents.
- Although DentaQuest policies and procedures described a severity rating scale, the policy/procedure submitted lacked definitions of these categories and did not describe when the ratings are assigned and how the ratings are used to determine actions needed or next steps.
- During the review period, customer service staff members and grievance and appeal staff members were directed to refer member complaints to a dental consultant; however, minimal criteria were stated in policy regarding which complaints should be referred.
- DentaQuest's policies and procedures did not address reporting QOC issues or concerns to any regulatory agencies. During the interview, DentaQuest staff members reported that the Department is not notified of QOC concern review activity and that the outcome of QOC concern reviews would be reported to licensing agencies only if the outcome was the termination of the provider.

To address these opportunities, HSAG recommends DentaQuest:

- Review and revise policies as needed to include definitions and to clearly articulate QOC processes and responsibilities. DentaQuest may want to consider using a flow chart to determine the processes to be included in policies and procedures.
- Review its processes related to reviewing complaints about QOC, and create a clear policy or cohesive set of documents to describe DentaQuest's processes for investigating.
- Develop written criteria, checklists, or examples of situations that would indicate a referral to the dental consultant is warranted. Once these criteria are developed, HSAG recommends that DentaQuest develop and implement training for Complaints, Grievances, and Appeals staff members, dental consultants, and any administrative staff members involved with reviewing QOC complaints.

- Consider clarifying policies and procedures with regard to reporting QOC grievances and concerns to regulatory agencies and working with the Department to determine which regulatory agencies should receive reporting and under what circumstances. Additionally, HSAG also recommends that DentaQuest work with the Department to define in policies and procedures the circumstances under which QOC investigations are reported to the Department and at what point in the investigation.

Follow-Up on FY 2021–2022 Recommendations

The QOC Grievances and Concerns Audit was not conducted for CHP+ MCEs in FY 2021–2022.

Appendix A. CHP+ Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for MY 2022 for measures with a hybrid option, along with the percentile ranking for each MY 2022 hybrid rate.

Table A-1—MY 2022 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Childhood Immunization Status			
Combination 3	78.95%	81.58%	≥90th
Combination 7	68.42%	71.05%	≥90th
Combination 10	52.63%	55.26%	≥90th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	64.65%	92.94%	≥90th
Counseling for Nutrition—Total	69.97%	84.18%	≥90th
Counseling for Physical Activity—Total	69.13%	83.21%	≥90th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	75.00%	NA	—

— indicates that the rate was not comparable to benchmarks.

Table A-2 shows RMHP's rates for MY 2022 for measures with a hybrid option, along with the percentile ranking for each MY 2022 hybrid rate.

Table A-2—MY 2022 Administrative and Hybrid Performance Measure Results for RMHP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Primary Care Access and Preventive Care			
Childhood Immunization Status			
Combination 3	64.38%	65.75%	50th–74th
Combination 7	61.64%	63.01%	75th–89th
Combination 10	37.67%	39.04%	50th–74th
Immunizations for Adolescents			
Combination 1	61.33%	62.04%	<25th
Combination 2	22.43%	23.11%	<25th

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	20.36%	84.72%	75th–89th
Counseling for Nutrition—Total	24.06%	73.89%	50th–74th
Counseling for Physical Activity—Total	18.52%	74.44%	50th–74th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	38.10%	95.24%	≥90th