FY 2023–2024 External Quality Review Technical Report for Child Health Plan *Plus*

January 2025

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

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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) 2023–2024.

In FY 2023–2024, 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 2023–2024 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 February 2023.[1] Additionally, 42 CFR §438.358 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 2023–2024.

Table 1-1—FY 2023–2024 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

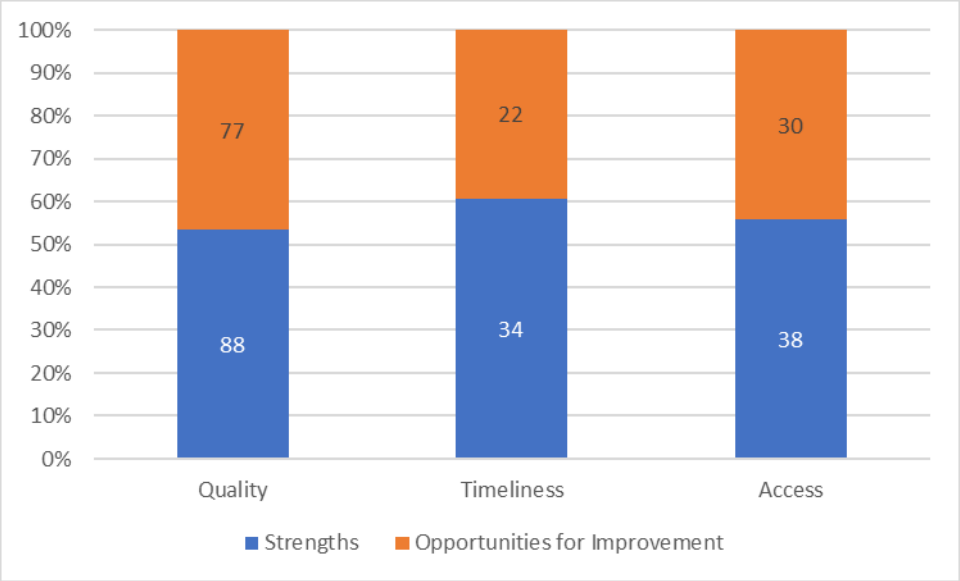
[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 7, 2024.

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 Information Systems Capabilities Assessment (ISCA) activity, HSAG collected and evaluated the capabilities of each MCE's information systems (IS) infrastructure to monitor network standards.	CHP+ MCOs and CHP+ PAHP
Optional Activities	
CAHPS Surveys (Protocol 6)	
HSAG annually administers the CAHPS 5.1H Child Medicaid Health Plan Survey with the HEDIS supplemental item set and Children with Chronic Conditions (CCC) measurement 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 (QOCGs) and QOC concerns (QOCCs).	CHP+ MCOs and CHP+ PAHP

Summary of FY 2023–2024 Statewide Performance Related to Quality, Timeliness, and Access

Figure 1-1 provides an overall assessment of the number 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 counts were derived from the results of all mandatory and optional EQR-related activities conducted for all Colorado CHP+ health plans during FY 2023–2024.

Figure 1-1—Number of Strengths and Opportunities for Improvement



**Each strength or 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, Validation of Network Adequacy, and QOC Grievances and Concerns Audit. 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 improvement, HSAG noted the CHP+ health plans' strengths ranged from 20 to 58 strengths. The CHP+ health plan with the most strengths demonstrated the most scores that were higher, although not statistically significantly, than the 2023 NCQA national averages and the FY 2022–2023 scores.

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 2023–2024 and includes graphics that depict the percentages of strengths and opportunities for improvement—derived from conducting mandatory and optional EQR activities in FY 2023–2024—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 2023–2024. 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 2022–2023 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 entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[1]

Timeliness

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

Access

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

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

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

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

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

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[2]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the health plan designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 6, 2024.

component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the health plan improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the health plans with specific feedback and recommendations. The health plans used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with the CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the health plan adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.

- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     – All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     – All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     – Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each health plan. HSAG then identified common themes and the salient patterns that emerged across the health plans related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed CMS EQR Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the health plans, HSAG assigned each PIP topic 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

accessibility, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-1.

Table 2-1—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

Health Plan	PIP Topic	Quality	Timeliness	Access
COA	*Social Determinants of Health Screening*	✓		
	Child and Adolescent Well-Care Visits	✓		✓
DHMP	*Improving Social Determinants of Health Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services*	✓		
	Improving Well-Care Visit Rates for Child and Adolescent DHMP CHP+ Members	✓		✓
Kaiser	*Social Determinants of Health Screening*	✓		
	Well-Child Visits	✓		✓
RMHP	*Improving the Rate of Social Determinants of Health Screening for CHP+ Members*	✓		
	Well-Child Visit Rates for RMHP CHP+ Members	✓		✓
DentaQuest	*Social Determinants of Health Screening—Member Survey*	✓		
	Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations	✓		✓

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 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) 2023, regardless of the auditing firm. These processes and activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[3]

- 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.
  - Computer database and file structure review.
  - Discussion and feedback sessions.

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

- 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 2023 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 2023 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) 2024 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.[4] 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 2023 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2022. 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 2023. This symbol may also indicate that a percentile ranking was not determined, either because the MY 2023 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:
  - Ranked at or above the 75th percentile without a statistically significant decline in performance from HEDIS MY 2022.

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

  - Ranked between the 50th and 74th percentiles with statistically significant improvement in performance from HEDIS MY 2022.
- 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 2022.

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 2021, MY 2022, and MY 2023 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:

- The 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 2-2 presents the measures provided in the report that can be reported using the hybrid methodology.

Table 2-2—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 2-3.

Table 2-3—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 (ED) Visit for Mental Illness	✓	✓	✓
Follow-Up After ED 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: ED 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 A—Administrative Data
- IS M—MRR Processes
- IS C—Clinical and Care Delivery Data
- IS R—Data Management and Reporting

In the measure results tables presented in Section 4, MY 2021, MY 2022, and MY 2023 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 2021, MY 2022, and MY 2023, 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 and State requirements into 11 standards consisting of related regulations and contract requirements (42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]). Table 2-4 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 2-4—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, 2023–2024
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, 2023–2024
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines	2015–2016, 2018–2019, 2021–2022

Standard Number and Title	Regulations Included	Years Reviewed
Standard IX—Subcontractual Relationships and Delegation	438.230	2017–2018, 2020–2021, 2023–2024
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS)	438.236 438.240 438.242 438.330	2015–2016, 2018–2019, 2021–2022, 2023–2024
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 2023–2024 compliance review process, the standards reviewed were Standard V—Member Information Requirements; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; and Standard X—QAPI, CPGs, and HIS.

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*, February 2023.[5] Table 2-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-5—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 2023–2024 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 materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 6, 2024.

For this step,	HSAG completed the following activities:
	• 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 2-6 depicts the relationship between the standards and the domains of care.

Table 2-6—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard V—Member Information Requirements			✓
Standard VII—Provider Selection and Program Integrity		✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—QAPI, CPGs, and HIS	✓	✓	

Validation of Network Adequacy

HSAG conducted two distinct activities in FY 2023–2024 designed to assist the Department in understanding the adequacy of the provider networks across the state: time and distance analysis and ISCA.

Objectives

Time and Distance Analysis

The purpose of the FY 2023–2024 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.

As required in 42 CFR §438.350(a), states which contract with MCOs must have a qualified EQRO perform an annual EQR that includes NAV to ensure provider networks are sufficient to provide timely and accessible care to beneficiaries across the continuum of services. The Department contracted with HSAG as its EQRO to conduct NAV analyses of the Medicaid and CHP+ healthcare practitioner, practice group, and entity networks for all MCEs during FY 2023–2024.

HSAG conducted the FY 2023–24 NAV according to the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4), confirming each MCE's ability to collect reliable and valid network adequacy monitoring data, to use sound methods to assess the adequacy of its managed care networks, and to produce accurate results to support MCE and the Department network adequacy monitoring efforts.

Information Systems Capabilities Assessment

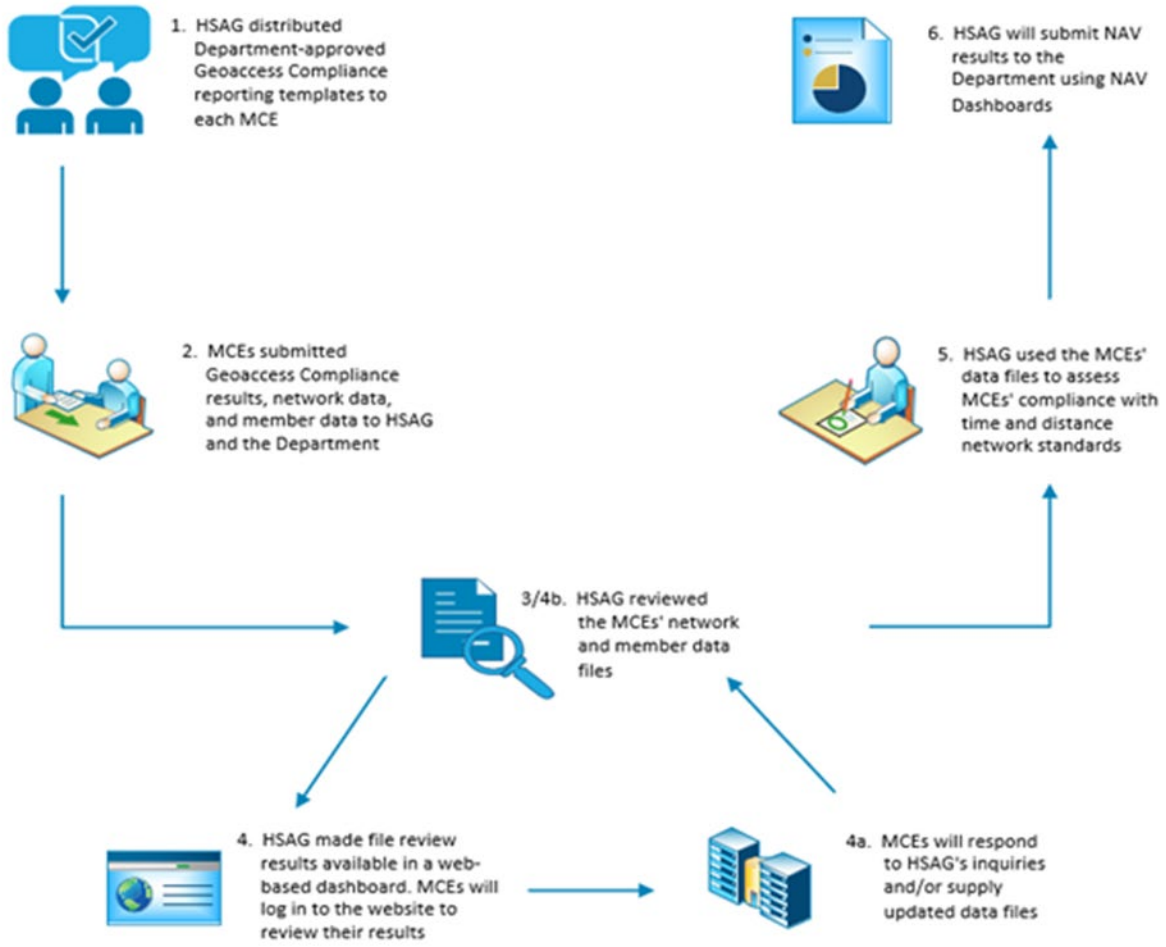
The purpose of the FY 2023–2024 ISCA was to collect and evaluate the capabilities of each MCE's IS infrastructure to monitor network standards in accordance with the requirements of CMS EQR Protocol 4. HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid services in Colorado, and presented findings and assessment of any concerns related to data sources used in the NAV.

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 2023–2024 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.[6,7] Table 2-7 presents the provider categories applicable to CHP+ MCEs; within each category, FY 2023–2024 NAV analyses were limited to categories corresponding to the MCEs' minimum time and distance network requirements.

Table 2-7—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 2023–2024, 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, 2023, HSAG notified each MCE of the January 31, 2023, deadline to submit the FY 2023–2024 Quarter 2 (Q2) network adequacy report and data files. Each MCE's notification included detailed data requirements and an 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 September 2023 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,

[6] 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 6, 2024.

[7] 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 substance use disorder [SUD]), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

practices, and entities enrolled in *interChange*.[8] 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, 2023, for FY 2023–2024 Q2. During FY 2023–2024, 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).

Information Systems Capabilities Assessment

HSAG prepared an ISCA document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCEs' IS and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level.

HSAG conducted an ISCA by using each MCE's completed Information Systems Capabilities Assessment Tool (ISCAT) and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCE tracks providers over time, across multiple office locations, and through changes in participation in the MCE's network. The ISCAT was used to assess the ability of the MCE's IS to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

HSAG hosted an MCE-wide webinar focused on providing technical assistance to the MCEs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines. Validation activities were conducted via interactive virtual review and are referred to as "virtual review," as the activities are the same in a virtual format as in an on-site format.

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 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*.

[8] *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.

During the FY 2023–2024 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).

Information Systems Capabilities Assessment

HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG assessed data and documentation from MCEs that included, but was not limited to, network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks.

HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness. HSAG required each MCE that calculated the Department-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the Department-defined performance indicator specifications. HSAG required each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCE took for indicator calculation.

Additionally, HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

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 2023–2024. 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.
- 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.[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.

Information Systems Capabilities Assessment

HSAG conducted a virtual review with the MCEs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

HSAG evaluated the MCE's IS, focusing on the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCE oversight of external IS, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

[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: Dec 6, 2024.

HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures.

HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source IS matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by the MCE or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

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.

Information Systems Capabilities Assessment

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 2-8.

Table 2-8—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have Significant Bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 2-9 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 2-9—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has Significant Bias on the results	*No Confidence*

CAHPS Surveys

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about parents'/caretakers' of child members experience with the healthcare their child received.

Technical Methods of Data Collection

HSAG administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set for the CHP+ population. Child members included as eligible for the survey were 17 years of age or younger as of September 30, 2023. All parents/caretakers of sampled members completed the surveys from December 2023 to May 2024.

RMHP was required to contract with its own survey vendor to conduct a CAHPS survey for CHP+ members enrolled in its CHP+ health plan. RMHP used a certified vendor, SPH Analytics, to conduct the CAHPS survey on behalf of the CHP+ health plan. RMHP's survey vendor administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set. Child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. To support the reliability and validity of the findings, NCQA requires standardized sampling and data collection procedures related to the selection of members and distribution of surveys to those members. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. RMHP reported that NCQA methodology was followed. RMHP provided HSAG with the data to calculate the results presented in this report.

For COA, DHMP, and Kaiser, the survey administration protocol employed was a mixed mode methodology, which allowed for three methods by which parents/caretakers of child members could complete a survey: (1) mail, (2) Internet, or (3) telephone. A cover letter was mailed to all parents/caretakers of sampled child members that provided two options by which they could complete the survey in English or Spanish: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey via a URL or quick response (QR) code and designated username. Parents/caretakers of child members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter and survey. Parents/caretakers of child members who were not identified as Spanish speaking received an English version of the cover letter and survey. The English and Spanish versions of the first and second cover letters included a toll-free number that respondents could call to request a survey in another language (i.e., English or Spanish). Non-respondents received a reminder postcard, followed by a second survey mailing and a second reminder postcard. The name of the CHP+ health plan appeared in the questionnaires and cover letters, the letters included the signature of a high-ranking state official, and the questionnaire packages included a postage-paid reply envelope addressed to the organization conducting the surveys. Computer assisted telephone interviewing (CATI) was conducted for parents/caretakers of sampled child members who did not complete a survey. HSAG followed a staggered method of up to six

CATI calls to each non-respondent at different times of the day, on different days of the week, and in different weeks.

For RMHP, a mixed mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letters followed by telephone interviews of non-respondents with up to four CATI calls) was used for data collection. Respondents were given the option of completing the survey in English or Spanish.

The survey included a set of standardized items (76 items) that assess parents'/caretakers' perspectives on their child's care. The survey questions were categorized into 14 measures of experience that included four global ratings, four composite measures, one individual item measure, and five CCC composites/items. 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*). The individual item measure is an individual question that looks at coordination of care. The CCC composite and item measures are sets of questions and individual questions that look at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* or *Access to Specialized Services*).[10] If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

For each global rating, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each composite measure, the *Coordination of Care* individual item measure, the *Access to Specialized Services* CCC composite measure (CCC population only), and the *Family-Centered Care (FCC): Getting Needed Information* and *Access to Prescription Medicines* CCC item measures (CCC population only), the percentage of respondents who chose a positive or top-box response was calculated. Response choices for these measures were "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for these measures was defined as a response of "Usually" or "Always." For the *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* CCC composite measures (CCC population only), the percentage of respondents who chose the top-box experience response (a response value of "Yes" from response choices of "Yes" and "No") was calculated.

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 2023–2024 scores were compared to their corresponding FY 2022–2023 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2023–2024 top-box scores and the

[10] The CCC composite and item measures are only calculated for the CCC population. They are not calculated for the general child population.

FY 2022–2023 top-box scores are noted with directional triangles. A CHP+ health plan's score that was statistically significantly higher in FY 2023–2024 than FY 2022–2023 is noted with a green upward triangle (▲). A CHP+ health plan's score that was statistically significantly lower in FY 2023–2024 than FY 2022–2023 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 2023 NCQA national averages.[11,12,13] 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's 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 2-10.

[11] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

[12] Quality Compass® 2023 data are used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

[13] Quality Compass® data were not available for 2024 at the time this report was prepared; therefore, 2023 data were used for this comparative analysis.

Table 2-10—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

CAHPS Topic	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	✓		
Coordination of Care	✓		
Access to Specialized Services (CCC population only)	✓		✓
FCC: Personal Doctor Who Knows Child (CCC population only)	✓		
Coordination of Care for Children with Chronic Conditions (CCC population only)	✓		
Access to Prescription Medicines (CCC population only)	✓		✓
FCC: Getting Needed Information (CCC population only)	✓		

QOC Grievances and Concerns Audit

Objectives

This report will use the term "QOCG," which will include the subset of QOCCs and potentially significant patient safety issues. In an effort to understand the QOCG 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 QOCGs. 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, QOCG case review sample, and teleconference interviews.

Description of Data Obtained

Policies, procedures, desktop protocols, process documents, and member and provider informational materials regarding QOCGs were obtained from the MCEs. In addition, HSAG requested that each MCE submit a complete list of all QOCGs 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 QOCG 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 QOCGs.

How Conclusions Were Drawn

The sample of potential QOCG 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 2023–2024. 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).

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, NAV ratings, and PIPs.

Technical Methods of Data Collection

Data were gathered for performance measures, CAHPS, compliance audits, NAV ratings, 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, NAV ratings, 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, NAV ratings, 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, 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, NAV ratings, 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 Rating by Plan* table represents the prior years' 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.
- *NAV Rating scores* are divided into the ratio indicator and the time/distance indicator confidence levels.
- The *PIP* results are divided into clinical and nonclinical ratings. Additional detail on the ratings can be found via the tooltip.

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

Validation of Performance Improvement Projects

Table 3-1 shows the FY 2023–2024 statewide PIP results for the CHP+ health plans.

Table 3-1—FY 2023–2024 Statewide PIP Results for the CHP+ Health Plans

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
COA	*Social Determinants of Health Screening*	100%	100%	*High Confidence*	*Not Assessed*		
	Child and Adolescent Well-Care Visits	100%	100%	*High Confidence*	*Not Assessed*		
DHMP	*Improving Social Determinants of Health Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services*	100%	100%	*High Confidence*	*Not Assessed*		
	Improving Well-Care Visit Rates for Child and Adolescent DHMP CHP+ Members	100%	100%	*High Confidence*	*Not Assessed*		
Kaiser	*Social Determinants of Health Screening*	100%	100%	*High Confidence*	*Not Assessed*		
	Well-Child Visits	100%	100%	*High Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
RMHP	*Improving the Rate of Social Determinants of Health Screening for CHP+ Members*	100%	100%	*High Confidence*	*Not Assessed*		
	Well-Child Visit Rates for RMHP CHP+ Members	100%	100%	*High Confidence*	*Not Assessed*		
DentaQuest	*Social Determinants of Health Screening—Member Survey*	85%	88%	*Low Confidence*	*Not Assessed*		
	Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Statewide Conclusions and Recommendations Related to Validation of PIPs

During FY 2023–2024, the CHP+ MCOs and the CHP+ PAHP (MCEs, collectively) initiated new clinical and nonclinical PIPs. The MCEs' clinical PIP topics varied and were selected by the MCEs from a list of approved topics identified by the Department. The MCEs' nonclinical PIPs focused on one topic selected by the Department, which focused on increasing the percentage of members screened for social determinants of health (SDOH). The MCEs reported the PIP designs and baseline results for the FY 2023–2024 validation. For the FY 2023–2024 validation, HSAG evaluated each MCE's PIP for adhering to acceptable PIP methodology and assigned a validation rating. All CHP+ MCOs received a validation rating of *High Confidence* for this year's validation of the clinical and nonclinical PIPs. The CHP+ PAHP, DentaQuest, received *High Confidence* for the clinical PIP and *Low Confidence* for the nonclinical PIP. The PIPs had not progressed to being evaluated for the second validation rating, which evaluates achieving significant improvement; therefore, the second validation rating was *Not Assessed*

for all PIPs. In FY 2024–2025, when the MCEs report Remeasurement 1 results, the PIPs will be evaluated and assigned a confidence level for both validation ratings.

Based on the FY 2023–2024 PIP validation activities, HSAG identified the following statewide strengths:

- The MCEs followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- The MCEs reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

Based on the FY 2023–2024 PIP validation activities, HSAG did not identify any statewide opportunities for improvement. The opportunities for improvement specific to DentaQuest's nonclinical PIP, and HSAG's recommendations, are provided in Section 4.

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 MY 2023. 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. Please note that this table presents performance measure rates reported using administrative methodology.

Table 3-2—MCO and Statewide Results for MY 2023

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Primary Care Access and Preventive Care					
Child and Adolescent Well-Care Visits					
Total	49.66%	54.66%	51.08%	44.46%	49.73%
Childhood Immunization Status					
Combination 3	71.01%	82.14%	58.33%	64.42%	69.90%
Combination 7	64.61%	75.00%	55.21%	59.62%	63.87%
Combination 10	42.58%	51.79%	39.58%	37.50%	42.32%
Chlamydia Screening in Women					
16 to 20 Years	38.71%	76.40%	35.96%	28.04%	42.70%
Developmental Screening in the First Three Years of Life					
Total	65.35%	66.78%	73.33%	54.30%	65.03%
Immunizations for Adolescents					
Combination 1	68.92%	67.83%	75.31%	64.73%	69.02%
Combination 2	34.24%	40.87%	40.74%	28.42%	34.56%
Lead Screening in Children					
Lead Screening in Children	43.64%	46.43%	9.47%	37.50%	39.01%
Screening for Depression and Follow-Up Plan					
12 to 17 Years	24.75%	25.80%	2.83%	10.12%	19.25%

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Weight Assessment and Counseling for Nutrition and Physical Activity Children/Adolescents					
Body Mass Index (BMI) Percentile—Total	19.23%	74.80%	94.04%	18.02%	31.64%
Counseling for Nutrition—Total	25.67%	78.17%	93.99%	24.57%	37.15%
Counseling for Physical Activity—Total	18.93%	77.31%	94.14%	20.43%	31.86%
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.64%	60.00%	50.00%	66.23%	61.94%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.70%	57.14%	62.35%	70.54%	68.11%
Maternal and Perinatal Health					
Contraceptive Care—All Women					
Most or Moderately Effective Contraception (MMEC)—15 to 20 Years	17.46%	18.75%	17.93%	22.42%	18.12%
Long-Acting Reversible Contraception (LARC)—15 to 20 Years	3.06%	5.50%	4.10%	5.04%	3.61%
Contraceptive Care—Postpartum Women					
MMEC—15 to 20 Years—3 Days	NA	NA	NA	NA	NA
MMEC—15 to 20 Years—90 Days	NA	NA	NA	NA	NA
LARC—15 to 20 Years—3 Days	NA	NA	NA	NA	NA
LARC—15 to 20 Years—90 Days	NA	NA	NA	NA	NA
Prenatal and Postpartum Care					
Timeliness of Prenatal Care—Under 21 Years	NA	NA	80.00%	54.17%	59.86%
Postpartum Care—Under 21 Years	NA	NA	84.00%	51.39%	61.97%
Care of Acute and Chronic Conditions					
Asthma Medication Ratio					
5 to 18 Years	67.25%	60.00%	NA	NA	67.98%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
3 Months to 17 Years	75.00%	NA	100.00%	87.10%	79.47%
Behavioral Health Care					
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—6 to 17 Years	75.31%	NA	NA	NA	65.83%
30-Day Follow-Up—6 to 17 Years	83.95%	NA	NA	NA	77.50%
Follow-Up After ED Visit for Substance Use					
7-Day Follow-Up—13 to 17 Years	22.22%	NA	NA	NA	23.40%
30-Day Follow-Up—13 to 17 Years	41.67%	NA	NA	NA	40.43%
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—6 to 17 Years	55.28%	NA	NA	NA	56.40%
30-Day Follow-Up—6 to 17 Years	76.40%	NA	NA	NA	71.56%

Performance Measure	COA	DHMP	Kaiser	RMHP	Statewide Weighted Average
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	41.45%	NA	NA	59.38%	43.55%
Continuation and Maintenance Phase	44.62%	NA	NA	NA	49.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose Testing—Total	54.90%	NA	NA	NA	56.78%
Cholesterol Testing—Total	28.43%	NA	NA	NA	30.51%
Blood Glucose and Cholesterol Testing—Total	27.45%	NA	NA	NA	29.66%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	76.54%	NA	NA	NA	71.43%
Use of Services					
Ambulatory Care: ED Visits					
0 to 19 Years	28.95	22.37	20.83	16.76	26.21

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 2023 measure rates were determined to be high-performing rates (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2022, or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2022) for the CHP+ statewide weighted average:

- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3, Combination 7, and Combination 10*
- *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*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—13 to 17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6 to 17 Years* and *30-Day Follow-Up—6 to 17 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6 to 17 Years*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

Statewide Conclusions and Recommendations Related to Performance Measures

The following statewide HEDIS MY 2023 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 2022) for the CHP+ statewide weighted average:

- *Chlamydia Screening in Women—16 to 20 Years*
- *Immunizations for Adolescents—Combination 1*
- *Lead Screening in Children*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

To address these low measure rates, HSAG recommends:

- For the *Chlamydia Screening in Women* measure, the Department work with the CHP+ MCOs to ensure providers are trained to address sexually transmitted infection (STI) stigma and on how to discuss STI screenings with members. Encourage CHP+ MCOs mail a screening card reminder with information on regular women's health checkups, such as pap smear and STI screenings. In addition, HSAG recommends that the Department work with the CHP+ MCOs on tracking chlamydia screening rates so the CHP+ MCOs can report provider-specific rates to physicians and large practices. Finally, HSAG recommends the Department work with the CHP+ MCOs to ensure all lab results are being reported directly to the MCOs, in addition to reports sent to providers.[14]
- For the *Lead Screening in Children* and *Chlamydia Screening in Women* measures, the Department consider working with the CHP+ MCOs to ensure comprehensive screening occurs across all providers serving children and adolescents. HSAG encourages the CHIP+ MCOs and the Department to work together with providers to identify and address the factors contributing to the low rates for preventive screenings for children and adolescents (e.g., barriers to accessing care such as limited providers or transportation issues, provider billing issues, administrative data source challenges).
- For the *Immunizations for Adolescents—Combination 1* measure indicator and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator, the Department work with the CHP+ MCOs to provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. As part of that effort, HSAG recommends that the Department work with the CHP+ MCOs to create provider reports that indicate which members have care gaps in these areas to help focus outreach for scheduling visits.

[14] National Committee for Quality Assurance. *Improving Chlamydia Screening*. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on: Dec 3, 2024.

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 (2020–2021, 2023–2024)*	**95%~**	**86%v**	**86%v**	**100%^**	**89%^**	**91%^**
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 (2020–2021, 2023–2024)*	**94%v**	**94%^**	**100%^**	**100%^**	**87%~**	**95%^**
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%~	97%v	100%~	100%~	100%	95%v
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**25%v**	**25%v**	**75%~**	**75%~**	**100%~**	**60%v**
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS) (2021–2022, 2023–2024)*	**100%^**	**100%~**	**100%~**	**100%~**	**81%^**	**96%^**

Description of Standard	COA	DHMP	Kaiser	RMHP	Denta-Quest**	Statewide Average
Standard XII—Enrollment and Disenrollment (2022–2023)	100%	100%	100%	100%	100%	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*
***FY 2019–2020 was the first year of review for DentaQuest.*

^ *Indicates an increase from review three years prior.*
v *Indicates a decrease from review three years prior.*
~ *Indicates no change from review three years prior.*

Table 3-4 presents the compliance scores for record reviews conducted for each MCE during FY 2023–2024.

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%

NA: DHMP did not report any grievances during the review period, therefore, the scores are not applicable (NA).

Statewide Conclusions and Recommendations Related to Assessment of Compliance

Based on the four standards reviewed in FY 2023–2024, HSAG found the following common strengths among the MCEs:

- Member materials were provided in alternative formats such as being printed in large font size, braille, and audio.
- The MCEs were able to describe in detail an adequate overview of their credentialing programs, including how they address recruitment and retention, how they review provider applications, and how the credentialing process captures the required information for vetting.
- Quality and appropriateness of care for members with special healthcare needs (SHCN) was addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.
- CPGs were adopted, disseminated, and reviewed at least biennially, and included a process for soliciting feedback from contracted providers.

- The HIS for the MCEs were robust and included methods to collect, process, and report data to and from the State.

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

- Some MCEs' electronic provider directories did not include the provider website URLs, as required; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.
- Language located in some MCE notices was not in an easy to understand format and did not test at a sixth-grade reading level.
- A few MCE documents had taglines that were not in a conspicuously visible font size and did not include how to request auxiliary aids and services.
- Some MCEs had inconsistent information across multiple documents when describing the time frame required for sending a member requested information in paper form.
- Some MCE policies and procedures did not state that the MCE would not knowingly employ any staff members who are debarred or suspended.
- Most MCEs were missing required federal language in subcontractor agreements.

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

- Make corrections to the provider directory to include the direct URL to the provider website, whether the provider completed cultural competency training, and whether the provider has accommodations for people with disabilities.
- Review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.
- Revise the taglines in documents that include conspicuously visible font size and how to request auxiliary aids and services.
- Update policies and procedures to be consistent with the time frame required for sending the member requested information in paper form.
- Review the entire member handbook to identify where it does not include easily understood language and then implement changes necessary to obtain language in a format that is easy to follow.
- Modify policies and procedures to align in full detail with the federal and State requirements that the MCE would not knowingly employ any staff members who are debarred or suspended.

Validation of Network Adequacy

Time and Distance Analysis

Statewide Results

Quarterly during FY 2023–2024, 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 2023–2024 Q2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2023, through December 31, 2023.

For an MCE to be compliant with the FY 2023–2024 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).

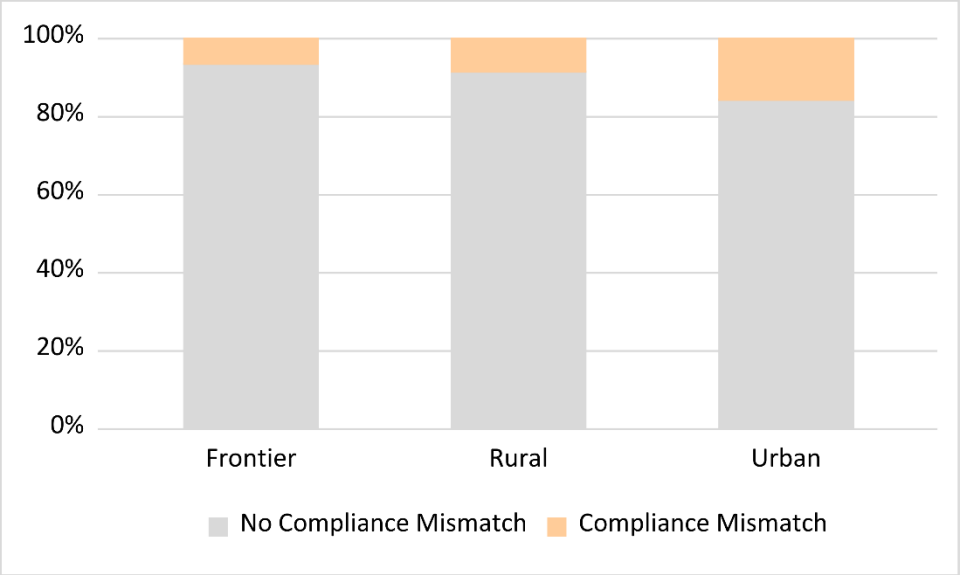
CHP+ MCO Results

This section summarizes the FY 2023–2024 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 2023–2024 Q2 by Urbanicity

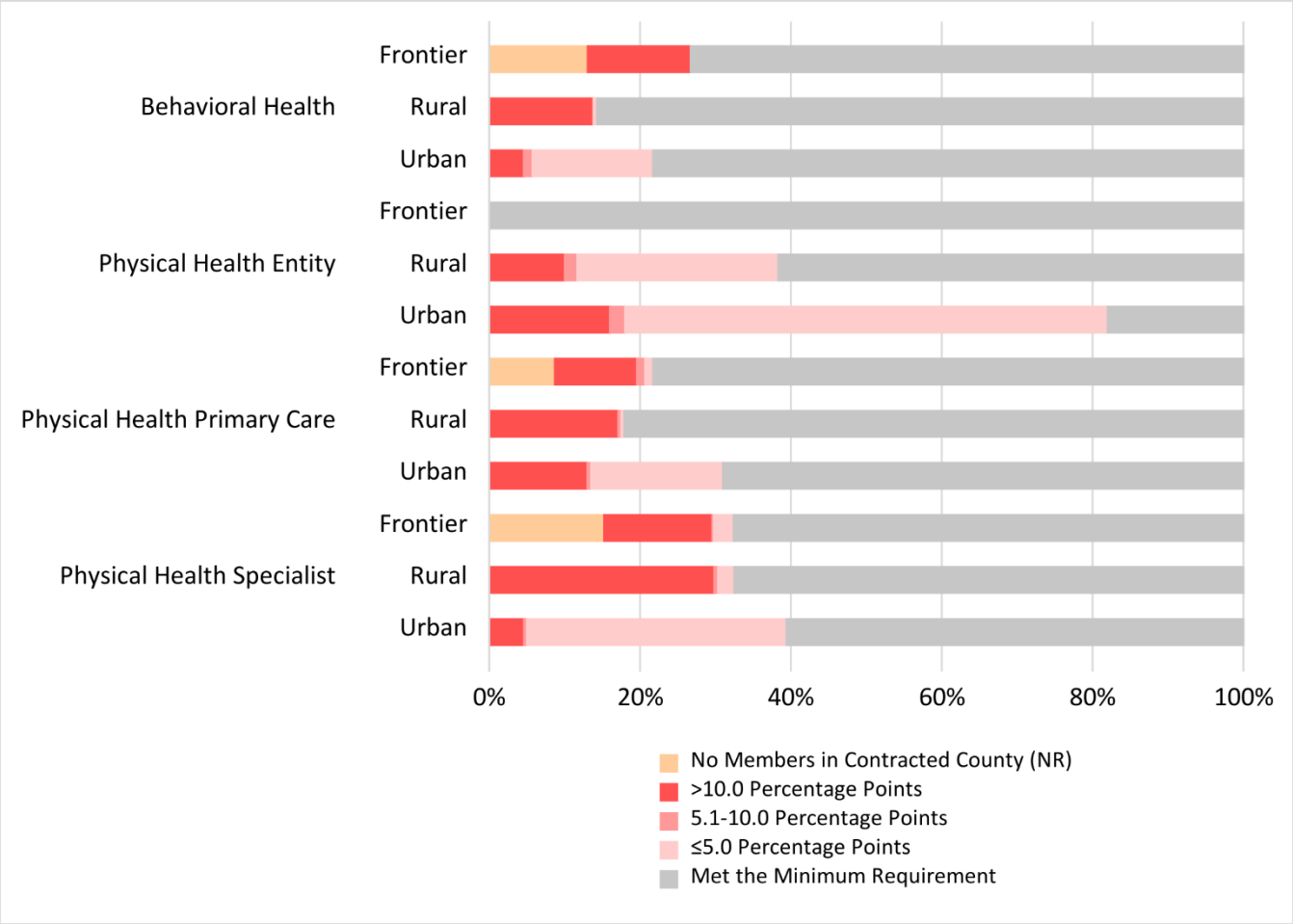


As shown in Figure 3-1, HSAG agreed with 93.5 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 91.5 percent of reported results for rural counties, and 84.3 percent of reported results for urban counties.

Access Level Assessment

Figure 3-2 displays the percentage of BH and PH primary care network 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 2023–2024 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, 2023



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, Table 3-2 summarizes the number of BH and PH entity, primary care, and 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.

- 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. The 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.

- Minimum time and distance PH entity requirements include Acute Care Hospitals and Pharmacies. The 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.
- Minimum time and distance PH primary care requirements include Pediatric, Adult, and Family Primary Care Practitioner, as well as practitioners specializing in OB/GYN services. The CHP+ MCOs are required to ensure that all members have two PH primary care practitioners from each specified network type available within the specified network requirements.
- Minimum time and distance PH specialist requirements include practitioners such as cardiologists, endocrinologists, and gastroenterologists, etc. The 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.

Behavioral Health

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.

HSAG assessed a total of 546 BH results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county BH results, 73.3 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes). An additional 13.7 percent of the results were greater than 10.0 percentage points away from the minimum network requirements, and 13.0 percent of aggregated results had no CHP+ MCO members within the appropriate age range for the BH requirements.
- Of the aggregated rural county BH results, 85.7 percent met the minimum network requirements, 0.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 13.8 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county BH results, 78.3 percent met the minimum network requirements, 16.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 4.6 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Entities

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.

HSAG assessed a total of 156 PH entity results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county PH entity results, 100 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members had access to PH entities within the minimum network requirements).
- Of the aggregated rural county PH entity results, 61.7 percent met the minimum network requirements. An additional 26.7 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.7 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 10.0 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county PH entity results, 18.0 percent met minimum network requirements, 64.0 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.0 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 16.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Minimum time and distance PH primary care requirements include Adult Primary Care Practitioner, Pediatric Primary Care Practitioner, and Family Practitioner, as well as practitioners specializing in OB/GYN services. CHP+ MCOs are required to ensure that all members have two primary care providers (PCPs) from each specified network type available within the specified network requirements. For example, the CHP+ MCO should contract with two or more Pediatric Primary Care Practitioners (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.

HSAG assessed a total of 624 PH primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county PH primary care results, 78.3 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members had access to PH primary care within the minimum network requirements). An additional 1.1 percent were less than or equal to 5.0 percentage

points away from the minimum network requirements, 1.1 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, 10.9 percent were greater than 10.0 percentage points away from the minimum network requirements, and 8.7 percent had no CHP+ MCO members within the appropriate age range for the PH primary care requirements.

- Of the aggregated rural county PH primary care results, 82.1 percent met the minimum network requirements, 0.4 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.4 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 17.1 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county PH primary care results, 69.0 percent met the minimum network requirements, 17.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.5 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 13.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Specialist

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 Cardiology specialty providers 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.

HSAG assessed a total of 1,560 PH specialist results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county PH specialist results, 67.6 percent met the minimum network requirements, 2.6 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.2 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, 14.3 percent were greater than 10.0 percentage points away from the minimum network requirements, and 15.2 percent had no CHP+ MCO members within the appropriate age range for the PH specialist requirements.
- Of the aggregated rural county PH specialist results, 67.5 percent met the minimum network requirements, 2.2 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.5 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 29.8 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county PH specialist results, 60.6 percent met the minimum network requirements, 34.4 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.4 percent were within 5.1 to 10.0 percentage points of the minimum

network requirement, and 4.6 percent were greater than 10.0 percentage points away from the minimum network requirements.

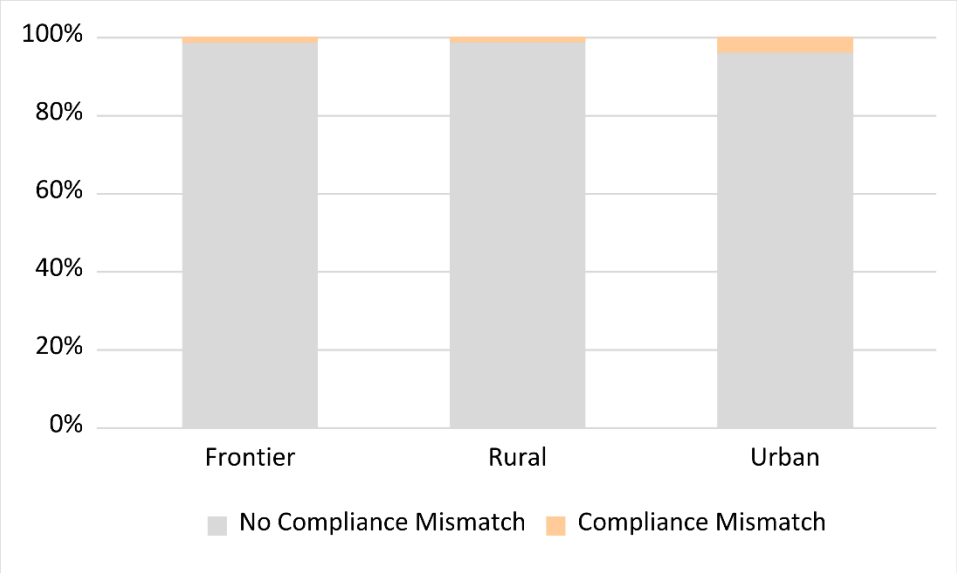
PAHP Results

This section summarizes the FY 2023–2024 NAV findings specific to the PAHP.

Compliance Match

Figure 3-3 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 3-3—Aggregate PAHP Geoaccess Compliance Validation Results for FY 2023–2024 Q2 by Urbanicity

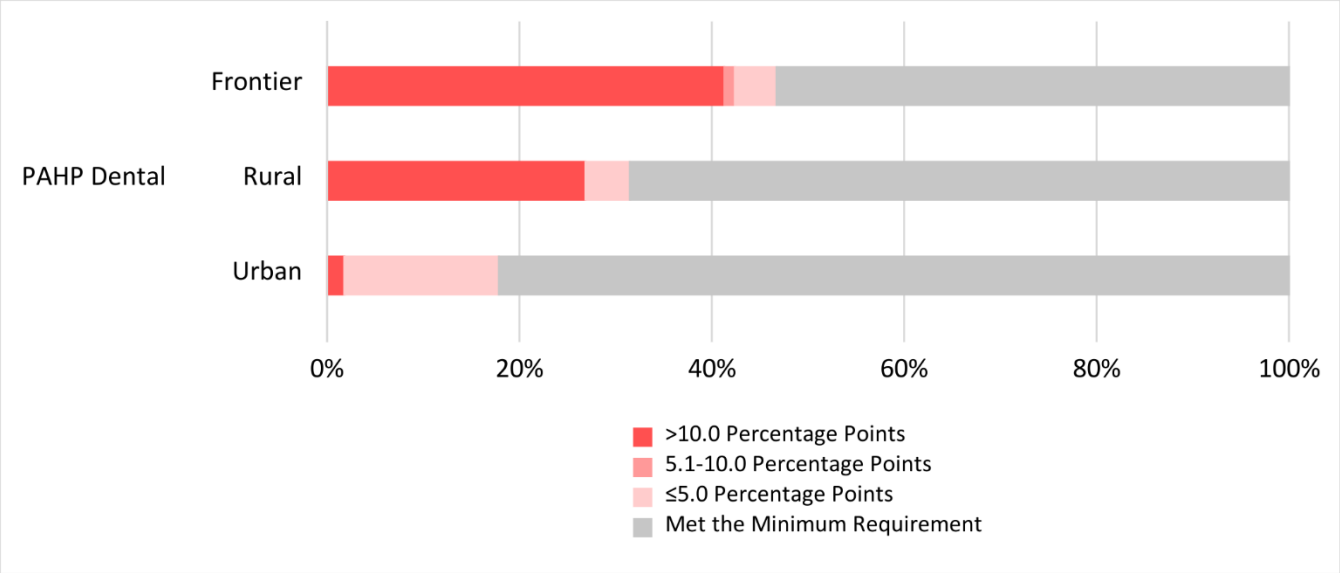


As shown in Figure 3-3, HSAG agreed with 98.9 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 99.1 percent of reported results for rural counties, and 96.4 percent of reported results for urban counties.

Access Level Assessment

Figure 3-4 displays the percentage of dental network results 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 2023–2024 Q2.

Figure 3-4—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



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 3-4 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.

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.

Dental Services

HSAG assessed a total of 256 dental service results, summarizing the percentage of members within each minimum network requirement and Colorado county the PAHP is contracted to serve.

- Of the aggregated frontier county dental service results, 53.3 percent met the minimum network requirements. An additional 4.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 41.3 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county dental service results, 68.5 percent met the minimum network requirements. An additional 4.6 percent of the results were less than or equal to 5.0 percentage

points away from the minimum network requirements, and 26.9 percent were greater than 10.0 percentage points away from the minimum network requirements.

- Of the aggregated urban county dental service results, 82.1 percent met the minimum network requirements. An additional 16.1 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 1.8 percent were greater than 10.0 percentage points away from the minimum network requirements.

Information Systems Capabilities Assessment

HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid services in Colorado, and presented findings and assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for each of the MCEs assessed. Additionally, HSAG determined that each MCE's data collection procedures were acceptable. Fifty percent of the MCEs did not rely on an external delegated entity for network adequacy indicator reporting during the reporting period. For the MCEs that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified requiring correction within the last year.

Statewide Results

Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the MCEs' interpretation of data was accurate. Table 3-5 presents the HSAG calculated validation ratings for each of the MCEs.

Table 3-5—Validation Ratings by CHP+ MCE[1]

MCE	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
COA	78.7%	21.3%	0%	0%
DentaQuest	100%	0%	0%	0%
DHMP	44.8%	55.2%	0%	0%
Kaiser	6.0%	44.8%	0%	49.3%
RMHP	100%	0%	0%	0%

[1] The percentages presented in the tables are based on the total number of indicators assessed and what percentage of the indicators scored *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence/Significant Bias* overall. The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

Generally, the MCEs received a validation rating of *Moderate Confidence* to *High Confidence* for the network adequacy indicators, with the exception of one MCE, which received a *Significant Bias* for 49.3 percent of the network adequacy indicators. The most common issues identified were the calculation of ratios utilizing provider locations instead of unique providers and the method of calculating time and distance based on straight line distance versus driving distance.

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 93.5 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, and HSAG agreed with 98.9 percent of the PAHP quarterly compliance results for frontier counties.

Table 3-6—Aggregate Percentage of Geoaccess Compliance Matches for FY 2023–2024 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	93.5%	91.5%	84.3%
PAHP	98.9%	99.1%	96.4%

Based on FY 2023–2024 time and distance and ISCA activities, HSAG identified the following strengths:

- The CHP+ MCOs exhibited strength across the BH network category, particularly for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements.
- The CHP+ MCOs demonstrated strength in Pediatric Behavioral Health and Pediatric Psychiatrists and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements.
- The PAHP performed well across the contracted counties for General Dentists with 89 percent of the contracted counties meeting all minimum network requirements.
- HSAG and the MCEs agreed with at least 84.3 percent of the MCEs' quarterly compliance results across all urbanicities.
- HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the assessed MCEs.
- HSAG determined that all MCEs had acceptable data collection procedures.

Based on the FY 2023–2024 time and distance and ISCA activities, HSAG identified the following opportunities for improvement:

- The PAHP was not able to meet the minimum network requirements for Oral Surgeons in 54.7 percent of the contracted counties.
- Across each of the CHP+ MCOs' contracted counties, 94.8 percent did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals.
- The most common issues identified were the calculation of ratios utilizing provider locations instead of unique providers and the method of calculating time and distance based on straight line distance versus driving distance.
- One MCE received an assessment of *Significant Bias* for 49.3 percent of the network adequacy indicators. HSAG observed that this MCE used a standard different that those set forth by the Department. Since the MCE used standards divergent from the Department's requirements, there are elements determined to have *Significant Bias*, which result in a validation rating of *No Confidence*.

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

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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.

CAHPS Surveys

Statewide Results

General Child Results

Table 3-7 shows the general child CAHPS results for the four CHP+ MCO and the Colorado CHP+ program (i.e., combined results of the four CHP+ MCOs) for FY 2023–2024.[15]

Table 3-7—FY 2023–2024 General Child Statewide CAHPS Results for CHP+ MCO

Measure	COA	DHMP	Kaiser	RMHP	Colorado CHP+ Program
Rating of Health Plan	62.39%	65.33%	62.94%	62.54%	62.45%
Rating of All Health Care	73.35%	73.42%	67.72%	58.28% ↓	69.88%
Rating of Personal Doctor	75.87%	80.30%	79.75%	65.37% ↓	75.01%
Rating of Specialist Seen Most Often	78.97%+	67.99%+	67.40%+	82.53%+	77.10%
Getting Needed Care	86.44%	73.76%+	80.02%+	77.18%+	83.09%
Getting Care Quickly	86.31%	81.49%+	77.90%	88.38%	85.25%
How Well Doctors Communicate	95.69%	93.49%+	95.48%	92.65%	95.12%
Customer Service	87.84%+	72.13%+	85.17%+	85.46%+	85.40%
Coordination of Care	86.88%+	88.65%+	81.82%+	81.29%+	85.23%

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 2023–2024 score is statistically significantly higher than the Colorado CHP+ program.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the Colorado CHP+ program.*

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

CCC Results

Table 3-8 shows the CCC CAHPS results for the Colorado CHP+ program (i.e., combined results of the four CHP+ MCOs) for FY 2023–2024.[16]

Table 3-8—FY 2023–2024 CCC Statewide CAHPS Results for Colorado CHP+ Program

Measure	Colorado CHP+ Program
Rating of Health Plan	54.30%
Rating of All Health Care	59.44%
Rating of Personal Doctor	76.13%
Rating of Specialist Seen Most Often	78.26%+
Getting Needed Care	74.31%
Getting Care Quickly	85.71%
How Well Doctors Communicate	95.02%
Customer Service	82.08%+
Coordination of Care	81.58%+
Access to Specialized Services	55.22%+
FCC: Personal Doctor Who Knows Child	91.74%
Coordination of Care for Children with Chronic Conditions	70.17%+
Access to Prescription Medicines	86.44%
FCC: Getting Needed Information	91.61%

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.

[16] Due to a low number of respondents for the CCC population, HSAG is unable to present results at the CHP+ MCO level for comparison to the Colorado CHP+ program in this report (i.e., the CHP+ MCO-level results are not reportable).

Statewide Conclusions and Recommendations Related to CAHPS

General Child Results

The following CHP+ MCOs' FY 2023–2024 CAHPS scores were higher, although not statistically significantly, than the Colorado CHP+ program scores:

- COA (every measure except *Rating of Health Plan*)
- DHMP (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Coordination of Care*)
- Kaiser (*Rating of Health Plan*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*)
- RMHP (*Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *Customer Service*)

The following CHP+ MCO's FY 2023–2024 CAHPS scores were statistically significantly lower than the Colorado CHP+ program scores:

- RMHP (*Rating of All Health Care* and *Rating of Personal Doctor*)

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

- Including member experience topics, such as BH skills and care management, in newsletter articles, learning collaborative events, and webinar series.
- Encouraging providers to focus on emphasizing member healthcare experiences.
- Implementing a training series that focuses on member-centered communication skills such as: providing clear explanations, listening carefully to concerns, checking for understanding, and being considerate of the parents'/caretakers' perspectives.

CCC Results

Due to a low number of respondents for the CCC population, HSAG is unable to present results at the CHP+ MCO level for comparison to the Colorado CHP+ program in this report (i.e., the CHP+ MCO-level results are not reportable).

For additional information about the CHP+ CAHPS activities and results for FY 2023–2024, refer to the aggregate CHP+ CAHPS report on the Department's website.[17]

[17] Health Services Advisory Group, Inc. 2024 Colorado Child Health Plan *Plus* (CHP+) Member Experience Report, September 2024. Colorado Department of Health Care Policy & Financing. Available at: https://hcpf.colorado.gov/sites/hcpf/files/2024_CO%20CAHPS_CHP%2B_ExperienceRpt_Final.pdf. Accessed on: Dec 4, 2024.

QOC Grievances and Concerns Audit

Statewide Results

Table 3-9 presents the number of QOCGs and QOCCs each CHP+ MCE reported during calendar year (CY) 2023, and the average CHP+ member population for each CHP+ MCE.

Table 3-9—Number of QOCG and QOCC Cases by MCE

MCE	# of Investigated Cases	Average Population
COA	6	69,542
DHMP	0	10,035
Kaiser	3	11,682
RMHP	3*	13,276
DentaQuest	1	68,371
Total	**13****	**172,906**

**RMHP originally reported eight cases during the CY 2023 review period. However, during the record review, RMHP discovered that several cases were incorrectly attributed to CHP+. In the post-interview follow-up, RMHP confirmed the CHP+ MCO received three potential cases, only two of which were included in the record review for this audit.*

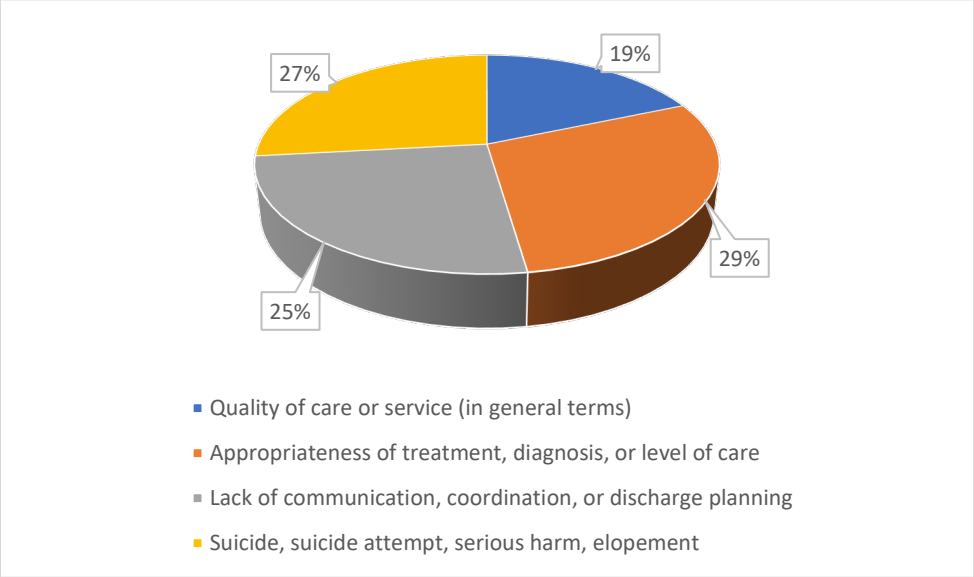
***The MCEs reported a total of 13 cases for review, but HSAG only reviewed a total of 12 cases for the review period due to an issue with RMHP documentation.*

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 (LOC)
- Lack of communication, coordination, or discharge planning
- Suicide, suicide attempt, serious harm, elopement

Figure 3-5 presents the percentage of cases reported in each case type category.

Figure 3-5—Percentage of Case Types for the CHP+ Program



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

Based on the FY 2023–2024 audit activities, HSAG identified the following strengths:

- All CHP+ MCEs had processes for investigating QOCGs or other QOC issues brought to the CHP+ MCEs.
- Record reviews demonstrated that all CHP+ MCEs, except one, followed their stated policies and procedures.
- Two of the five CHP+ MCEs used a two-factor rating scale to determine the severity level of the case investigated. The two-factor rating scale practice provided the CHP+ MCEs with a more detailed way to assess and understand the issues and/or actions needed.
- All CHP+ MCEs used a physician or equivalent (i.e., dentist) level of reviewer to make a final determination regarding action needed (e.g., corrective action, monitoring, review needed with peer review committee).
- Two CHP+ MCEs' policies documented procedures for following up with the member to determine if immediate healthcare needs are being met, or the QOCG is screened for imminent threat to member safety, and if present, the issue is to be referred to the appropriate team for member follow-up.

- One CHP+ MCE (Kaiser) provided a guide for grievance and appeal staff members to identify which complaints warrant referral to a clinical staff member. HSAG recognizes this as a best practice.

Based on the FY 2023–2024 audit activities, HSAG identified the following opportunities for improvement:

- The CHP+ MCEs did not have clear policies and procedures for reporting the receipt of QOCGs nor for submitting the QOC summary to the Department.
- DentaQuest's contract language did not include specific requirements regarding potential QOCGs or QOCCs.
- Most CHP+ MCEs did not have policies or procedures to address follow-up with the member to determine if the member's immediate healthcare needs were being met.

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

- Clarifying the expectations related to the contract requirement of Department notification of QOCGs and receipt of QOC summaries for each QOCG.
- Working with DentaQuest to provide clear requirements and expectations for addressing QOCGs.
- Providing the CHP+ MCEs with direction related to the member follow-up contract requirement.

Evaluating CHP+ MCE 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 is working to update its Quality Strategy in FY 2024–2025. 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 Medicaid population. The Department 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
- Medicaid 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 Strategic Pillars

In addition to the goals and objectives outlined in the Department's Quality Strategy, the Department has defined "strategic pillars" 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.

- Member Health: Improve quality of care and member health outcomes while reducing disparities in care.
- Care Access: Improve member access to affordable, high-quality care.
- Operational Excellence and Customer Service: Provide excellent service to members, providers, and partners with compliant, efficient, effective person- and family-centered practices.
- Health First Colorado Value: Ensure the right services, at the right place and the right price.
- Affordability Leadership: Reduce the cost of health care in Colorado to save people money on health care.

In consideration of the Department's goals and objectives and Colorado's 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:

- Monitor the newly implemented Universal Contracting Provisions to whether the updated process is working as intended to reduce administrative burden in the public health system, seek opportunities to clarify roles for all parties, and encourage value-based payments (VBPs).
- Continue to monitor and assess opportunities regarding preventive services through its associated performance measures, HEDIS/Core Set measures, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) participation reports, and claims and utilization data.

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

HSAG recommends the Department:

- Evaluate network adequacy time and distance reports in conjunction with NAV reports and compare against available claims and utilization data to further assess network gaps and underutilization of services.

  - Consider focused VBPs and alternative payment models (APMs) to address network gaps, particularly regarding SUD provider availability of specific Society of Addiction Medicine (ASAM) LOCs in rural and frontier counties, further supporting rural and frontier SUD providers with case management and transportation services.

- Continue its support of telemedicine by:
  - 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).
  - Engaging with the Office of eHealth Innovation regarding development and expansion of the Social Health Information Exchange (SHIE), specifically regional SHIE hubs to maximize funding to regional technology infrastructure and partnerships that align with the priorities of the region.

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 House Bill (HB) 22-1289, Cover all Coloradans, that expands Health First Colorado and CHP+ benefits for children and pregnant members, regardless of their immigration status.
- Encourage the MCEs to further invest in neighborhood health through community-based partnerships by supporting proven interventions that address health-related social needs (HRSN).
- 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 SHCN.
- Encourage the statewide adoption of additional evidence-based clinical practice guidelines 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.
  - In regard to CAHPS, the Department may consider adding the requirement for the dental CHP+ PAHP to participate in the CAHPS survey.
- 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. Prepare to evaluate the impact of HB 22-1289 and the expansion of Health First Colorado and CHP+ benefits.
- 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/Core Set measures and CAHPS, and custom-designed performance 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 quality improvement plans (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)[18] that applies a health equity lens across all programs and initiatives. The HEP aligns with the Governor's Executive Order 175, SB 21-18, which focuses on addressing health disparities. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the Medicaid program's efforts on

[18] 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: Dec 10, 2024.

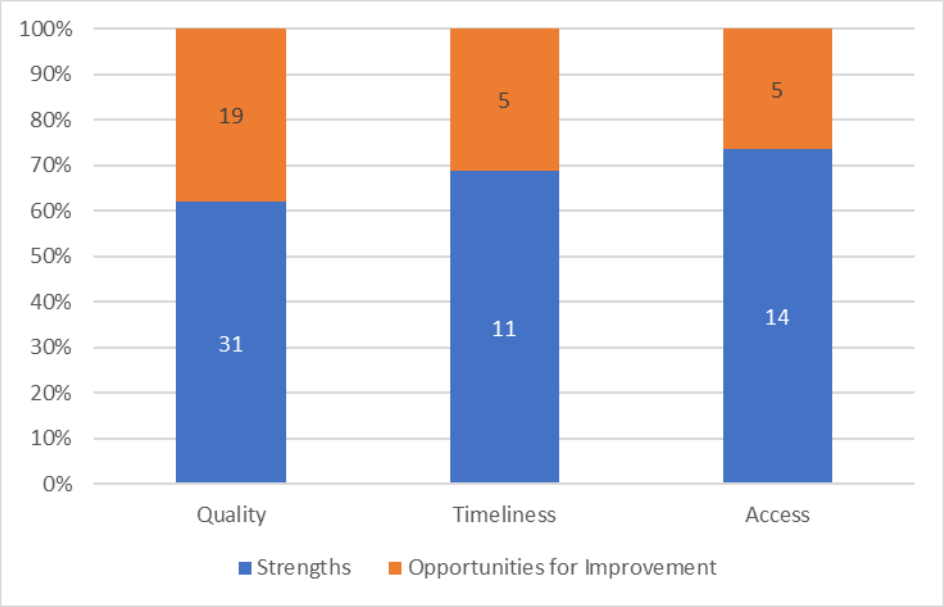
vaccinations, maternity and perinatal health, BH, and prevention, and aligns with CMS' Adult and Child Core Set measures. The Department provides member-level data (i.e., age, county, disability, gender, language, race, and ethnicity) to the MCEs to assist with identification of priority populations for healthcare initiatives. These efforts include ongoing work to close vaccination disparity gaps, maternity research and reporting, BH investments transformation, increasing access 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 Medicaid and CHP+ look-alike programs for children and pregnant members, regardless of immigration status.
- 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 RAEs and MCOs 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 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, a component of the SHIE, which helps prescribe programs or communicate care coordinators' access to health improvement programs (i.e., prenatal care; diabetes supports; or SDOH, such as Supplemental Nutrition Assistance Program [SNAP] and Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]).

The initiatives noted above and planned for the ACC Phase III and the 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—Number of Strengths and Opportunities for Improvement by Care Domain for COA*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

COA submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Child and Adolescent Well-Care Visits [WCV]* PIP and the nonclinical *Social Determinants of Health [SDOH] Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. COA resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 4-1 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *Child and Adolescent WCV*

Table 4-1—2023–2024 PIP Overall Confidence Levels for the *Child and Adolescent WCV* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Child and Adolescent WCV* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-2—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	75%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. COA received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *Child and Adolescent WCV*

Table 4-3 displays data for COA's *Child and Adolescent WCV* PIP.

Table 4-3—Performance Indicator Results for the *Child and Adolescent WCV* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of CHP+ MCO members 3–21 years of age who had at least one comprehensive WCV with a PCP or an OB/BYN practitioner during the measurement year.	N: 9,562 D: 22,567	42.37%					

N–Numerator D–Denominator

For the baseline measurement period, COA reported that 42.37 percent of CHP+ MCO members 3 to 21 years of age had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Nonclinical PIP: *SDOH Screening*

Table 4-4 displays data for COA's *SDOH Screening* PIP.

Table 4-4—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of CHP+ MCO members who were screened for SDOH using the Core 5 SDOH screening tool.	N: 0 D: 1,023	0%					

N–Numerator D– Denominator

For the baseline measurement period, COA reported that 0 percent of CHP+ MCO members were screened for SDOH using the Core 5 SDOH screening tool during the measurement year.

Interventions

Clinical PIP: *Child and Adolescent WCV*

Table 4-5 displays the barriers and interventions documented by the health plan for the *Child and Adolescent WCV* PIP.

Table 4-5—Barriers and Interventions for the *Child and Adolescent WCV* PIP

Barriers	Interventions
High volume of the eligible CHP+ MCO member population (over 20,000 members) can be difficult to reach for well-care visit reminders.	**Digital Engagement Programs**: COA has developed multiple digital engagement well-care visit programs that send out texts and phone calls to remind members to attend regular well-care visits and receive routine vaccinations. The digital engagement programs allow COA to target the unengaged CHP+ MCO member population (including parents/guardians) through a mode of communication that is accessible (text and phone calls) for members and less resource intensive for COA staff. This digital engagement program is tailored to each child's age and therefore provides age-appropriate recommendations and information to parents/guardians.
Anticipated increase in CHP+ MCO membership resulting from the end of the PHE and an associated increase in the CHP+ MCO performance indicator denominator.	**CHP+ MCO Health Risk Assessment (HRA) for newly enrolled CHP+ MCO members**: Newly enrolled CHP+ MCO members receive an HRA upon enrollment. HRA results are used by care managers to obtain a comprehensive understanding of each member's individual healthcare needs, including current risk factors and care gaps. It can be difficult to have touchpoints with all CHP+ MCO members, and the CHP+ MCO HRA allows our care management team to coordinate care activities that encompass a broad range of care plan goals and interventions including, but not limited to establishing PCP to complete well-care visits, age-appropriate screenings and immunizations, establishing behavioral health services, scheduling dental visits, and connecting members to necessary specialty providers.

Nonclinical PIP: SDOH Screening

Table 4-6 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-6—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Existing care management scripts ask members a variety of SDOH questions that do not cover all five SDOH core domains.	Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable care management scripts.
The internal COA HealthEdge GuidingCare system has not been updated since 2021. The older system has impacted the ability to update the care management scripts and workflows within the GuidingCare system in a timely manner.	**Optimization of the collection of SDOH data and reporting within HealthEdge GuidingCare.** The updated and upgraded GuidingCare system incorporates the SDOH Core 5 screening tool into the new and improved system and scripts.

COA: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for COA:

- COA followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- COA reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

COA: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. COA addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle and COA received *High Confidence* for the final Module 4 submission. COA's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2023 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 4-7 shows the performance measure results for COA for MY 2021 through MY 2023, along with the percentile rankings for each MY 2023 rate. Please note that this table presents performance measure rates reported using administrative methodology.

Table 4-7—Performance Measure Results for COA

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Total	48.16%	41.86%	49.66%^	50th–74th
Childhood Immunization Status				
Combination 3	65.97%	57.93%	71.01%^	75th–89th
Combination 7	57.35%	52.58%	64.61%^	75th–89th
Combination 10	46.81%	37.64%	42.58%	75th–89th
Chlamydia Screening in Women				
16 to 20 Years	34.66%	29.07%	38.71%^	10th–24th
Developmental Screening in the First Three Years of Life				
Total	NA	33.36%	65.35%^	BTSA
Immunizations for Adolescents				
Combination 1	76.45%	71.79%	68.92%	10th–24th
Combination 2	37.74%	33.31%	34.24%	25th–49th
Lead Screening in Children				
Lead Screening in Children	NA	30.88%	43.64%^	10th–24th
Screening for Depression and Follow-Up Plan				
12 to 17 Years	NA	14.47%	24.75%^	BTSA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	16.32%	17.90%	19.23%	<10th
Counseling for Nutrition—Total	13.92%	18.71%	25.67%^	<10th
Counseling for Physical Activity—Total	9.37%	13.20%	18.93%^	<10th

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	61.19%	52.51%	62.64%^	50th–74th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.48%	55.06%	68.70%^	50th–74th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years	NA	16.44%	17.46%	WTSA
LARC—15 to 20 Years	NA	2.86%	3.06%	WTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days	NA	NA	NA	—
MMEC—15 to 20 Years—90 Days	NA	NA	NA	—
LARC—15 to 20 Years—3 Days	NA	NA	NA	—
LARC—15 to 20 Years—90 Days	NA	NA	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—Under 21 Years	NA	NA	NA	—
Postpartum Care—Under 21 Years	NA	NA	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years	NA	58.29%	67.25%^	WTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years	NA	81.48%	75.00%	50th–74th
Behavioral Health Care				
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	76.27%	75.31%	≥90th
30-Day Follow-Up—6 to 17 Years	NA	86.44%	83.95%	75th–89th
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years	NA	22.58%	22.22%	50th–74th
30-Day Follow-Up—13 to 17 Years	NA	29.03%	41.67%	75th–89th
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6 to 17 Years	36.42%	30.08%	55.28%^	75th–89th
30-Day Follow-Up—6 to 17 Years	54.91%	72.36%	76.40%	50th–74th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	29.03%	36.62%	41.45%	25th–49th
Continuation and Maintenance Phase	38.60%	52.83%	44.62%	10th–24th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	50.00%	47.62%	54.90%	25th–49th
Cholesterol Testing—Total	27.19%	24.60%	28.43%	10th–24th

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Blood Glucose and Cholesterol Testing—Total	27.19%	23.81%	27.45%	10th–24th
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	72.00%	64.41%	76.54%	≥90th
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years	19.42	24.09	28.95	—

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.
— 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 that there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

COA: Strengths

The following HEDIS MY 2023 measure 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 2022; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2022):

- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—13 to 17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6 to 17 Years* and *30-Day Follow-Up—6 to 17 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6 to 17 Years*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* and *Well-Child Visits from 15 Months to 30 Months*

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

The following HEDIS MY 2023 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 2022):

- *Chlamydia Screening in Women*
- *Immunizations for Adolescents—Combination 1*
- *Lead Screening in Children*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total*
- *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*

To address these low rates, HSAG recommends COA:

- For the *Chlamydia Screening in Women* measure, ensure providers are trained to address STI stigma and on how to discuss STI screenings with patients. COA may consider mailing a screening card reminder with information on regular women's health checkups such as pap smear and STI screenings. In addition, HSAG recommends that COA track chlamydia screening rates and report provider-specific results to physicians and large practices. COA may consider requiring lab results from network providers to be reported directly to COA, in addition to usual reports sent to providers.[19]
- For the *Lead Screening in Children* and *Chlamydia Screening in Women* measures, consider ensuring comprehensive screening occurs across all network providers. COA has the opportunity to work with providers to identify and address the factors contributing to the low rates for preventive screenings for children and adolescents (e.g., barriers to accessing care such as limited providers or transportation, provider billing issues, administrative data source challenges).
- For the *Immunizations for Adolescents—Combination 1* indicator and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* indicator, provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. HSAG recommends that COA create a provider report that indicates which members have care gaps in this area to help focus outreach for scheduling visits.

[19] National Committee for Quality Assurance. *Improving Chlamydia Screening*. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on: Dec 5, 2024.

- For the *Follow-Up Care for Children Prescribed ADHD Medication* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures, work with its provider network to identify barriers to medication management visits with this population as well as interventions that may help to overcome some of the barriers (e.g., member incentives, care management supports, transportation assistance). To be effective, these medications must be taken as prescribed, and side effects must be monitored closely by a pediatrician with prescribing authority or a child psychiatrist.

Follow-Up on FY 2022–2023 HEDIS Measure Recommendations

FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG recommended 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 recommended 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 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 COA's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- COA reported ongoing work within its prenatal program, Healthy Mom Healthy Baby, which provides both a care management and digital intervention component. The care management program screens pregnant mothers for past pregnancy history, complications, and other conditions or behaviors that could contribute to a high-risk pregnancy. A care manager contacts the mother during each trimester of pregnancy and after the baby is born to provide support and education to these mothers. Furthermore, COA reported that it enrolls all eligible pregnant members into a digital engagement component of the program where members receive SMS (text messages) with educational messages timed to gestational age or birth age, as well as interactive surveys and reminders to improve maternal and child health outcomes. Text messages are intended for pregnant members and new parents with babies up to age one. In 2022, COA reported that the CHP+ program expanded to cover women for 12 months postpartum, and programming was expanded to match that time frame.

- New steering councils and committees have been formed to recommend strategies to improve performance metrics and support workgroups for enhancing population health outcomes by prioritizing measures for high-impact areas of improvement and increased collaboration among providers to share best practices and scale interventions across the network.

HSAG recognizes that the implementation of the Healthy Mom Healthy Baby program with the digital engagement component and the steering councils and committees are likely to help improve and maintain performance rates.

Assessment of Compliance With CHIP Managed Care Regulations

COA Overall Evaluation

Table 4-8 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 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-8—Summary of COA Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information Requirements	21	21	20	1	0	0	95%~
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%v
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (QAPI, CPGs, and HIS)	17	17	17	0	0	0	100%^
Totals	**58**	**58**	**53**	**5**	**0**	**0**	**91%***

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

^ *Indicates an increase from review three years prior.*

v *Indicates a decrease from review three years prior.*

~ *Indicates no change from review three years prior.*

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 (2019–2020, 2022–2023)	78%	88%
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	100%	100%
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	100%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	88%	100%
Standard V—Member Information Requirements (2020–2021, 2023–2024)*	**95%**	**95%**
Standard VI—Grievance and Appeal Systems (2020–2021, 2022–2023)	88%	90%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**100%**	**94%**
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**100%**	**25%**
Standard X—QAPI, CPGs, and HIS (2021–2022, 2023–2024)*	**94%**	**100%**
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*

***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: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, COA demonstrated consistently high-achieving scores across three out of four standards from the previous review cycle. Most notably, Standard X—QAPI, CPGs, and HIS improved by 6 percentage points from the previous review cycle, indicating a strong understanding of most federal and State regulations. However, the most significant decrease was Standard IX—Subcontractual Relationships and Delegation, which declined 75 percentage points from the previous review cycle.

COA: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG identified the following strengths for COA:

- COA maintained policies pertaining to effective communication, accessibility, and cultural sensitivity that outlined the steps COA takes to ensure effective communication with members, including testing readability, keeping the message simple, and understanding the audience.
- COA established a clear reporting structure from the Core Policy team and Provider Performance Committee up through the Executive Compliance Committee to the Finance, Audit, and Compliance Committee (FACC), and ultimately to the Board of Directors.
- Within its QAPI Program Description and Annual Quality Report, COA described a comprehensive program that included processes to address the appropriateness of care, quality of care, and member experience. Quality and appropriateness of care for members with SHCN was addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.
- COA reviewed CPGs annually and included a process for soliciting feedback from contracted providers. The CPGs were adopted and disseminated to providers and members.

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

HSAG found the following opportunities for improvement:

- COA did not include the provider website URLs within its electronic provider directory, as required.
- COA did not have written provisions stating that it would not knowingly employ any staff members who are debarred or suspended.
- Staff members were unaware of the status of certain contracts and were unable to communicate a process that addressed poor subcontractor performance.
- Some subcontractor agreements did not include required language, delegated activities or obligations, and reporting responsibilities.

To address these opportunities for improvement, HSAG recommends COA:

- Update its provider directory to include the provider URLs.
- Revise its policies and procedures to align in full detail with the federal and State requirements.

- Maintain ultimate responsibility of subcontractor agreements by ensuring centralized oversight of all agreements and ensure that a written process is developed to address subcontractor performance.
- Ensure that all contracts specify the delegated activities or obligations and related reporting responsibilities.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended COA:

- Update claim procedures to further delineate provider administrative clean claims issues from member-related issues in which a service is denied or partially denied. Additionally, enhance policies, procedures, and monitoring to ensure that the member is notified in writing of the denial or partial denial of a service.
- Enhance monitoring procedures to ensure that all authorization decisions are made within required time frames.
- Make necessary system and procedural updates to ensure that templates being used for CHP+ denials do not include references to continuation of benefits or EPSDT, but do include information about the member's right to appeal under the State's Children and Youth Mental Health Treatment Act (CYMHTA), when applicable.
- Enhance its monitoring system to ensure that the appeal acknowledgement letters are sent within two working days.
- Clarify the language on its website (i.e., that continuation of benefits only applies to Medicaid LOBs and does not apply to CHP+ members) is consistent with its policies.
- Remove the inaccurate statement in its Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing.

Assessment of COA's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 corrective action plan (CAP), COA updated policies and procedures to enhance member notifications in writing of the denial or partial denial of a service. COA enhanced monitoring procedures to ensure all authorization decisions were made within the required time frames. Necessary system and procedure updates were conducted to ensure the templates that were being used for CHP+ denials did not include references to continuation of benefits or EPSDT, but in addition, did include information about the member's right to appeal under the CYMHTA. Additional monitoring was enhanced to ensure appeal acknowledgement letters were sent within two working days. Regarding continuation of benefits, language was removed from the appeals resolution letters and, lastly, COA removed inaccurate language in the Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing. HSAG recognizes that updating and enhanced monitoring is likely to result in long-term improvements.

Validation of Network Adequacy

COA: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for COA:

- COA CHP+ met the minimum network requirements for Pediatric Behavioral Health and for Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.
- Across all frontier and rural counties, COA CHP+ met the minimum network requirements for Family Practitioner (MD, DO, NP, CNS, and PA), Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Pediatric SUD Treatment.
- COA CHP+ met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), General Behavioral Health, and General Psychiatrists and other Psychiatric Prescribers across all rural and urban counties.
- COA CHP+ met the minimum network requirements in frontier counties for Acute Care Hospitals, Pediatric Surgery, and Pharmacies, as well as met the minimum network requirements for General SUD Treatment and General Surgery across all rural counties.
- COA CHP+ has improved upon its provider specialty matching since converting to the use of HealthRules Payor (HRP), as it now relies solely upon the use of taxonomy codes for specialty matching instead of its previous process that included the use of multiple values (i.e., specialty description and provider types) to identify provider specialty.
- COA CHP+ maintains detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.

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

HSAG found the following opportunities for improvement:

- COA CHP+ did not meet the minimum network requirements for the Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for 100 percent of rural counties, 93.3 percent of frontier counties, and 85.7 percent of urban counties.
- COA did not meet the minimum network requirements for more than 50 percent of the contracted counties for the following pediatric specialists: Endocrinology; Gastroenterology;

Otolaryngology/Ear, Nose, and Throat (ENT); Ophthalmology; Neurology; and Pulmonary Medicine.

- COA CHP+ indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when COA is informed of a change in member demographic information.

To address these opportunities for improvement, HSAG recommends COA:

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that 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.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that COA:

- 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.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of COA's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- COA updated the provider directory with data refreshed every evening. COA reports that within its directory a form is available that anyone, including members, may use to report incorrect data or issues accessing providers listed in the directory.
- COA described that all credentialed providers are listed in COA's provider directory with information related to provider specializations, location, clinic office hours, status of accepting new members, cultural competency, race/ethnicity, gender, pronouns, Americans with Disabilities Act (ADA) accessibility, and languages spoken. The provider directory also lists all BH subspecialties and ASAM LOCs, increasing the ability to identify and connect members to the appropriate level of specialized care.
- COA reported that credentialing and provider data maintenance teams at COA entered provider data into COA's credentialing database using several different sources including information provided through the provider application and required appendix, as well as Council for Affordable Quality Healthcare (CAQH) summaries.
- COA reported that the inability to meet indicated time and distance standards is due to the taxonomy codes for SUD treatment facilities (particularly ASAM 3.1 and above) not tracking to the correct category. COA obtains taxonomy code information from the Department MCO report based on how providers fill out their information for the Department's provider validation. However, these taxonomy codes do not always align with a provider's National Provider Identifier (NPI) provider type and may not be validated at the location level.

Based on the above response, COA worked to address the NAV and PDV recommendations from FY 2022–2023, 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 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

CAHPS Survey

Findings

Table 4-10 shows the general child results achieved by COA for FY 2021–2022 through FY 2023–2024.

Table 4-10—General Child Results for COA

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	68.46%	64.13%	62.08% ↓
Rating of All Health Care	65.66%	68.36%	72.99%
Rating of Personal Doctor	75.42%	76.23%	75.71%
Rating of Specialist Seen Most Often	62.00%+	70.37%+	79.25%+
Getting Needed Care	83.25%	81.45%	86.33%
Getting Care Quickly	83.59%	86.16%	86.62%
How Well Doctors Communicate	97.36%	94.78%	95.79%
Customer Service	92.48%+	90.63%+	86.96%+
Coordination of Care	82.54%+	84.06%+	86.76%+

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 2023–2024 score is statistically significantly higher than the 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present CHP+ health plan-level results in this report.

COA: Strengths

The following measures' FY 2023–2024 scores for COA were higher, although not statistically significantly, than the 2023 NCQA national averages:

- *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*
- *Coordination of Care*

The following measures' FY 2023–2024 scores for COA were higher, although not statistically significantly, than the FY 2022–2023 scores:

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

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

The following measure's FY 2023–2024 score for COA was statistically significantly lower than the 2023 NCQA national average:

- *Rating of Health Plan*

The following measures' FY 2023–2024 scores for COA were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*
- *Rating of Personal Doctor*
- *Customer Service*

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

- Involving staff members at every level to assist in improving the member experience.
- Obtaining feedback from parents/caretakers of CHP+ members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of CHP+ members experiences, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of CHP+ members perspectives. Physicians could ask questions about parents'/caretakers' of CHP+ members concerns, priorities, and values and listen to their answers.

- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage parents/caretakers of CHP+ members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Exploring ways to direct parents/caretakers of CHP+ members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To follow up on recommendations related to the FY 2022–2023 CAHPS, COA reported engaging in the following QI initiatives:

- COA gathered supplemental feedback through member satisfaction surveys, developed with input from members and member-facing teams. Those surveys provided actionable insights and were guided by COA's Member Advisory Council, internal teams, and population health data. In spring 2023, questions on racial, cultural, and ethnic identities, as well as general member experience questions, were included in the survey. By spring 2024, COA continued with recurring questions on improvement to member experience and added questions on health-related social needs and member communication preferences. COA reported developing a new initiative to create a community feedback loop. COA described that the project will assess the current state of how COA seeks member feedback, pilot an improved member feedback loop model, and explore incentive models for member and community participation.
- COA reported conducting an internal satisfaction survey with the goal of collecting, understanding, and addressing data regarding disparities within its population that may contribute to lower performance among specified race or ethnicity groups, age groups, ZIP Codes, and other demographics. This allowed COA to analyze qualitative responses such as access to care issues and timeliness of services in conjunction with demographic data.
- COA developed and implemented a CAHPS communication plan that included detailed information on the CAHPS survey, covering its purpose, data collection timeline, and its benefits to members and providers. This information, along with links to CAHPS results, were communicated through various channels such as the provider manual, monthly provider updates, the internal COA employee newsletter, the member newsletter, and COA's social medical platforms. Provider-facing teams were available to address any provider questions regarding the CAHPS survey and reported any barriers encountered to internal staff members.

Assessment of COA's Approach to Addressing FY 2022–2023 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 2023, COA received and investigated six potential QOCG cases. COA's average CHP+ membership in CY 2023 was 69,542, with 45,469 members enrolled as of December 31, 2023. Of the six QOCG cases investigated by COA, four cases were substantiated.

COA: Strengths

Based on QOCG and QOCC audit activities in FY 2023–2024, HSAG found the following strengths for COA:

- In addition to sending an educational letter to a facility after two reported cases, COA staff members met with the facility to address the pattern of QOCGs.
- A QOC training video and emails were used to inform COA staff members about the importance of identifying and reporting QOCGs.
- All six cases demonstrated COA's adherence to sending acknowledgment letters within 24 business hours and closing cases in less than 90 days.

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

HSAG found the following opportunities for improvement:

- COA did not have a policy or procedure for ensuring that appropriate member follow-up occurs.
- Policies and procedures only noted a goal of closing QOCG cases within 90 days but did not indicate a time frame for acknowledging receipt of QOCGs. During the interview, COA staff members shared that their internal goal is to acknowledge each QOCG within 24 business hours of receipt.
- COA's policies and procedures described the two-factor scoring system scores that would lead to a CAP; however, during the interview, COA staff members that that CAPs are more commonly issued due to patterns or trends.

- The *COA CHP+ Member Handbook* and the COA website included information about the process for filing a grievance, but the member materials did not distinguish between a "member grievance" and a "QOCG."
- COA did not submit or describe policies or procedures for informing the Department of receipt of a QOC or for submitting a QOC summary as detailed in the CHP+ MCO contract.

To address these opportunities, HSAG recommends COA:

- Establish clear follow-up processes to ensure that member follow-up is occurring to determine whether the member's immediate healthcare needs are being met, regardless of where the QOCG originates.
- Further define within the applicable policies and procedures its internal timeliness goals for acknowledging and investigating QOCGs.
- Define the thresholds for trending facilities to provide guidance and accountability related to implementation of CAPs.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Implement a process for notifying the Department that a QOCG has been received and expand its QOC summary process to include all QOCGs received, rather than just those referred by the Department.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

In FY 2022–2023, HSAG recommended COA:

- Develop written criteria, checklists, or examples of situations that would indicate a referral to the quality management (QM) team is warranted.
- Specify the required credentials for QOCG 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 QOCGs and under what circumstances.

Review and Assessment of COA's Approach to Addressing FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

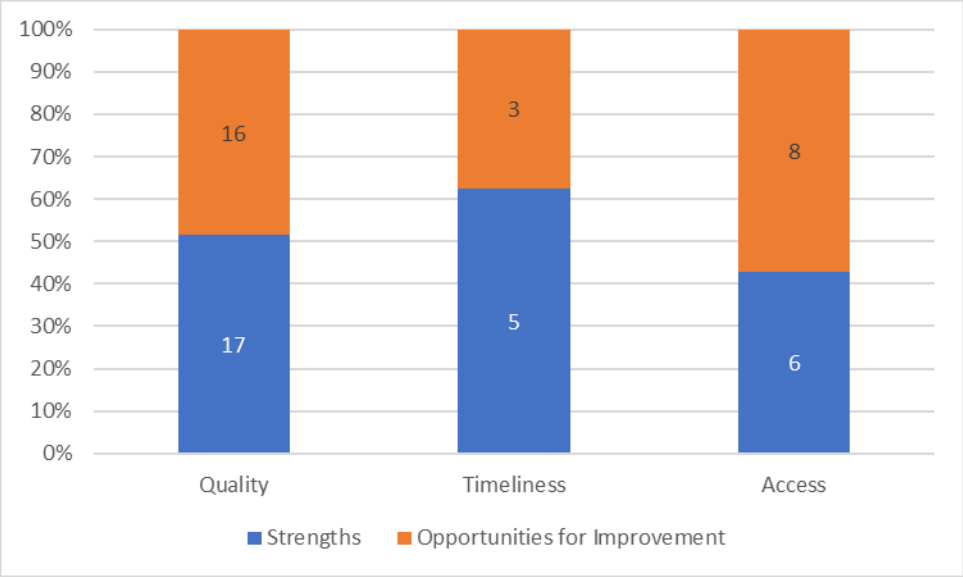
COA reported addressing HSAG's recommendations by:

- QI staff members working closely with customer service and care management staff members to ensure that all QOC issues are correctly identified and promptly forwarded to the Quality Department for investigations. Additionally, COA reported creating criteria and associated workflows based on new QOCG definitions to ensure all concerns are promptly and appropriately investigated once the Department implements the new QOCG process.
- Specifying required credentials for QOCG reviews based on new definitions and workflows once the Department implements the new QOCG process.
- Continuing to work closely with the Department to escalate QOCGs based on findings or required reporting. Additionally, COA reported creating a workflow based on new QOCG definitions to ensure concerns are reported to the Department and regulatory agencies, as appropriate, once the Department implements the new QOCG process.

COA still has the opportunity to address HSAG's recommendation of notifying the Department when a QOCG has been received and completing the required reporting. HSAG anticipates COA responses to the recommendations are likely to improve overall QOCG processes and increase compliance. HSAG encourages COA to continue training staff members to ensure all QOCGs are correctly identified and forwarded, as applicable. Additionally, COA should continue preparing for guidance from the Department for upcoming contractual changes and requirements.

Denver Health Medical Plan, Inc.

Figure 4-2—Number of Strengths and Opportunities for Improvement by Care Domain for DHMP*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

DHMP submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Improving Well-Care Visit [WCV] Rates for Child and Adolescent DHMP CHP+ Members* PIP and the nonclinical *Improving Social Determinants of Health [SDOH] Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. DHMP resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members*

Table 4-11—2023–2024 PIP Overall Confidence Levels for the *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	63%	*No Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received Met scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services*

Table 4-12—2023–2024 PIP Overall Confidence Levels for the *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	50%	38%	*No Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members*

Table 4-13 displays data for DHMP's *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP.

Table 4-13—Performance Indicator Results for the *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of CHP+ members ages 3–21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.	N: 1,111 D: 2,287	48.58%					

N–Numerator D–Denominator

For the baseline measurement period, DHMP reported that 48.58 percent of CHP+ MCO members ages 3 to 21 years had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services*

Table 4-14 displays data for DHMP's *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 4-14—Performance Indicator Results for the *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of DHMP CHP+ members who were empaneled at Denver Health, had at least one primary care visit at Denver Health	N: 382	36.49%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least one HRSN flowsheet question) completed in the past year.	D: 1,047						

N–Numerator D– Denominator

For the baseline measurement period, DHMP reported that 36.49 percent of CHP+ MCO members with at least one primary care visit at Denver Health Ambulatory Care Services were screened for SDOH during the measurement year.

Interventions

Clinical PIP: *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members*

Table 4-15 displays the barriers and interventions documented by the health plan for the *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP.

Table 4-15—Barriers and Interventions for the *Improving WCV Rates for Child and Adolescent DHMP CHP+ Members* PIP

Barriers	Interventions
• Lack of member awareness of the need for an annual well visit • Lack of transportation • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment • Lack of motivation to schedule and attend an annual well visit	Population Health outreach to members who are overdue for the annual well visit
• Lack of member awareness of the need for an annual well visit • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment	Automated reminder phone calls to members who are overdue for the annual well visit
Lack of motivation to schedule and attend an annual well visit	Member incentive for well visit completion

Nonclinical PIP: *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services*

Table 4-16 displays the barriers and interventions documented by the health plan for the *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 4-16—Barriers and Interventions for the *Improving SDOH Screening Rates for DHMP CHP+ Members Seen at Denver Health Ambulatory Care Services* PIP

Barriers	Interventions
Medical assistant (MA) staff turnover	Reviewing clinic workflows with MA staff to ensure SDOH screening occurs during the visit
• MA staff turnover • Competing priorities at visits	MyChart SDOH pre-visit screening offers the member an opportunity to complete the SDOH screening prior to the visit

DHMP: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- DHMP reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

DHMP: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. DHMP addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle and DHMP received High Confidence for the final Module 4 submission. DHMP's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2023 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 4-17 shows the performance measure results for DHMP for MY 2021 through MY 2023, along with the percentile rankings for each MY 2023 rate. Please note that this table presents performance measure rates reported using administrative methodology, while performance measure rates reported using hybrid methodology are presented in Appendix A.

Table 4-17—Performance Measure Results for DHMP

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Total	47.87%	43.71%	54.66%^	50th–74th
Childhood Immunization Status				
Combination 3	52.00%	78.95%	82.14%	≥90th
Combination 7	48.00%	68.42%	75.00%	≥90th
Combination 10	44.00%	52.63%	51.79%	≥90th
Chlamydia Screening in Women				
16 to 20 Years	38.33%	42.31%	76.40%^	≥90th
Developmental Screening in the First Three Years of Life				
Total	NA	55.12%	66.78%^	BTSA
Immunizations for Adolescents				
Combination 1	64.97%	82.73%	**67.83%^^**	10th–24th
Combination 2	42.94%	46.76%	40.87%	50th–74th
Lead Screening in Children				
Lead Screening in Children	NA	61.54%	46.43%	10th–24th
Screening for Depression and Follow-Up Plan				
12 to 17 Years	NA	33.60%	**25.80%^^**	BTSA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	72.47%	64.65%	74.80%^	25th–49th
Counseling for Nutrition—Total	77.72%	69.97%	78.17%^	75th–89th
Counseling for Physical Activity—Total	77.33%	69.13%	77.31%^	75th–89th

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.00%	NA	60.00%	50th–74th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	63.29%	63.89%	57.14%	<10th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years	NA	9.32%	18.75%^	BTSA
LARC—15 to 20 Years	NA	1.43%	5.50%^	BTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days	NA	NA	NA	—
MMEC—15 to 20 Years—90 Days	NA	NA	NA	—
LARC—15 to 20 Years—3 Days	NA	NA	NA	—
LARC—15 to 20 Years—90 Days	NA	NA	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—Under 21 Years	NA	NA	NA	—
Postpartum Care—Under 21 Years	NA	NA	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years	NA	NA	60.00%	WTSA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years	NA	NA	NA	—
Behavioral Health Care				
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	NA	NA	NA	—
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years	13.63	18.25	22.37	—

— Indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This 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.
— 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 that there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
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.

DHMP: Strengths

The following HEDIS MY 2023 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 2022; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2022):

- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*
- *Chlamydia Screening in Women—16 to 20 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*

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

The following HEDIS MY 2023 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 2022):

- *Immunizations for Adolescents—Combination 1*
- *Lead Screening in Children*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

To address these low rates, HSAG recommends DHMP:

- For the *Lead Screening in Children* measure, ensure comprehensive screening occurs across all network providers. DHMP may consider working with providers to identify and address the factors contributing to the low rates for preventive screenings for children and adolescents (e.g., barriers to accessing care such as limited providers or transportation, provider billing issues, administrative data source challenges).
- For the *Immunizations for Adolescents—Combination 1* indicator and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* indicator, HSAG recommends DHMP provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. HSAG recommends that DHMP create a provider report that indicates which members have care gaps in this area to help focus outreach for scheduling visits.
- For the *Well-Child Visits in the First 30 Months of Life* measure, work with its provider network to identify barriers to medication management visits with this population as well as interventions that may help to overcome some of the barriers (e.g., member incentives such as gift cards and baby supplies, care management supports, transportation assistance).

Follow-Up on FY 2022–2023 HEDIS Measure Recommendations

FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG recommended 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 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 DHMP's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- DHMP reported the use of multiple outreach campaigns, which included text message reminders three days before a well-child appointment for ages three and older to a guardian on file to remind them of their upcoming important well-child visit; and 24,889 mammogram reminder mailers to female members that included information on scheduling an appointment as well as a link to a calendar for the women's mobile clinic that allows members to schedule a mammogram at their home clinic and avoid travel to the Denver Health & Hospital Authority (DHHA) main campus.
- DHMP reported that it expanded an active partnership and collaboration in QI work group activities with DHHA Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, and annual visits. DHMP reported workgroups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum care, integrated BH, transitions of care, social determinants of health, immunizations, and ambulatory care. Additionally, DHMP reported it partnered in a collaborative work process with the QI director of ACS and ACS QI staff members to build joint QI interventions, including shared data analytics.

HSAG recognizes that the member outreach campaigns and expanding QI workgroups are moderately likely to help improve and maintain performance rates. DHMP did not report specific campaigns, programs, or interventions geared toward pregnant members.

Assessment of Compliance With CHIP Managed Care Regulations

DHMP Overall Evaluation

Table 4-18 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 2023–2024. No record reviews were conducted in FY 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-18—Summary of DHMP Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information Requirements	21	21	18	3	0	0	86%˅
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%^
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%˅
X. QAPI, CPGs, and HIS	17	17	17	0	0	0	100%~
Totals	**58**	**58**	**51**	**7**	**0**	**0**	**88%***

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

^ *Indicates an increase from review three years prior.*

˅ *Indicates a decrease from review three years prior.*

~ *Indicates no change from review three years prior.*

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 (2019–2020, 2022–2023)	97%	97%
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	88%	93%
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	60%	100%

Standard and Applicable Review Years	Previous Review	Most Recent Review**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	100%	100%
Standard V—Member Information Requirements (2020–2021, 2023–2024)*	**95%**	**86%**
Standard VI—Grievance and Appeal Systems (2020–2021, 2022–2023)	94%	77%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**93%**	**94%**
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%	97%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**75%**	**25%**
Standard X—QAPI, CPGs, and HIS (2021–2022, 2023–2024)*	**100%**	**100%**
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*

***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: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, DHMP demonstrated consistently high-achieving scores across two out of four standards; one of which improved from the previous review cycle, and one of which maintained 100 percent compliance, indicating a strong understanding of most federal and State regulations. However, most notably, Standard IX—Subcontractual Relationships and Delegation declined 50 percentage points from the previous review cycle.

DHMP: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG identified the following strengths for DHMP:

- DHMP established a detailed process to notify members affected by a contracted provider termination at least 30 calendar days prior to the effective termination date or 15 days after the receipt of the termination notice. 
- DHMP disseminated processes for detecting and preventing fraud, waste, and abuse, including the clear responsibilities of the chief executive officer, Board of Directors, Compliance Committee, and chief compliance and audit officer. 
- DHMP established processes to address data points around health equity, pediatric care, and maternal care. 

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

HSAG found the following opportunities for improvement:

- Language in the provider termination notices was not easily understood and did not test at a sixth-grade reading level.
- DHMP's formulary drug list and welcome letter's taglines were not in a conspicuously visible font size.
- The electronic provider directory located on the website did not include the direct URL to the provider website, whether the provider completed cultural competency training, and whether the provider has accommodations for people with disabilities.
- DHMP's policies and provider manual did not include "suspended" from participation in federal programs as a reason for not working with an entity.
- Written agreements with subcontractors did not include all required language.

To address these opportunities for improvement, HSAG recommends DHMP:

- Review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.
- Revise the tagline in the formulary drug list to be in a conspicuously visible font size.
- Make corrections to the provider directory to include the direct URL to the provider website, whether the provider completed cultural competency training, and whether the provider has accommodations for people with disabilities.
- Include "suspended" from participation in federal programs in its policy and provider manual.
- Update subcontractor agreements to include specific delegated activities, reporting responsibilities, and federal required language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended DHMP:

- Update its notice of adverse benefit determination (NABD) template to clarify that the member must ask for a State fair hearing within 120 days after the adverse appeal resolution and that any additional peer-to-peer efforts after receipt of the NABD need to occur as part of the appeals process and develop a process to ensure that the updated NABD is used consistently.

- Revise its member handbook to include the Bright Futures periodicity schedule with regard to well-care appointment timeliness standards and revise the Network Plan to include the 24-hour urgent care timeliness requirement.
- Remove any language that requires the member to sign and return a written appeal to DHMP.
- Update its NABDs and Grievance and Appeals section of its website to inform the members and the member representatives that this information must be provided upon request, free of charge, and sufficiently in advance of the appeal resolution time frame.
- Ensure that the member appeal resolution letters are written so that members can easily understand them.
- Make changes to the CHP+ website regarding the request for an expedited appeal to reflect the accurate 72-hour time frame set forth by federal and State regulations.
- Remove all language that references continuation of benefits in its appeal resolution letters, CHP+ member handbook, and on its website, as this does not apply to the CHP+ LOB.
- Revise the "State Fair Hearing" section of its website and its provider manual to inform the member that the contractor must 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 remove references to continuation of benefits, revise time frames for an expedited appeal to accurately state that it is 72 hours from the request, and clarify that the time frame to file a State fair hearing is 120 days from the adverse appeal resolution.

Assessment of DHMP's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, DHMP revised several documents to include the CHP+ member handbook, the CHP+ website, and multiple policies and procedures. Furthermore, DHMP developed a process to ensure that the updated NABD is used consistently. HSAG recognizes that updating inaccurate information through documents, policies, and procedures, and on the website is likely to result in long-term improvements.

Validation of Network Adequacy

DHMP: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for DHMP:

- DHMP CHP+ met minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS), Pediatric Primary Care Practitioner (MD, DO, NP, CNS), and Family Practitioner (MD, DO, NP, CNS) in all contracted counties. Additionally, DHMP CHP+ met the minimum network requirements for Adult Primary Care Practitioner (PA) in 75 percent of contracted counties.

- DHMP CHP+ met minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.
- DHMP CHP+ met minimum network requirements for General Urology in all contracted counties. While DHMP CHP+ did not meet the minimum network requirements for a number of general and pediatric specialty provider categories across contracted counties, the level of access for these provider categories was consistently 99 percent or greater.
- DHMP efficiently maintained the accuracy and completeness of provider information through its quarterly directory audit process. During each quarter, it evaluated a 20 percent sample of the provider directory. By year-end, it had thoroughly reviewed the entire directory.

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

HSAG found the following opportunities for improvement:

- DHMP CHP+ did not meet the minimum network requirements for Acute Care Hospitals; Gynecology, OB/GYN (PA); Pediatric SUD Treatment; Pharmacies; or Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for any of the contracted counties.
- DHMP CHP+ did not meet the minimum network requirement for any of the contracted counties for the following pediatric specialists: Cardiology, Endocrinology, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Otolaryngology/ENT, and Pulmonary Medicine.

To address these opportunities for improvement, HSAG recommends DHMP:

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that 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.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that DHMP:

- 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.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of DHMP's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- DHMP expanded the PH network by contracting with various specialty and PCP providers to increase options for members and opportunities for collaboration with new providers. These providers included vision providers, non-Denver Public Schools School Based Health Centers, and BH and SUD providers for CHP+.
- DHMP reviewed provider data collection processes for opportunities to improve information communicated in the provider directory.

Based on the above response, DHMP worked to address the NAV and PDV recommendations from FY 2022–2023, 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 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

CAHPS Survey

Findings

Table 4-20 shows the general child results achieved by DHMP for FY 2021–2022 through FY 2023–2024.

Table 4-20—General Child Results for DHMP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	65.79%	61.48%	66.51%
Rating of All Health Care	66.09%	66.90%	74.26%
Rating of Personal Doctor	78.40%	76.10%	81.06%
Rating of Specialist Seen Most Often	66.67%+	73.33%+	67.86%+
Getting Needed Care	68.21%+	78.75%+	73.56%+
Getting Care Quickly	77.22%+	78.49%+	80.10%+
How Well Doctors Communicate	93.84%+	94.48%+	93.01%+
Customer Service	82.36%+	82.67%+	74.04%+ ↓
Coordination of Care	86.36%+	81.63%+	89.29%+

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 2023–2024 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*
▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*
Due to a low number of respondents for the CCC population, HSAG is unable to present CHP+ health plan-level results in this report.

DHMP: Strengths

The following measures' FY 2023–2024 scores for DHMP were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measures' FY 2023–2024 scores for DHMP were higher, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Getting Care Quickly*
- *Coordination of Care*

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

The following measure's FY 2023–2024 score for DHMP was statistically significantly lower than the 2023 NCQA national average:

- *Customer Service*

The following measures' FY 2023–2024 scores for DHMP were lower, although not statistically significantly, than the FY 2022–2023 scores:

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

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:

- Exploring any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with parents/caretakers of CHP+ members. Specialists could ask questions about parents'/caretakers' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Obtaining feedback from parents/caretakers of CHP+ members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.

- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of CHP+ members experiences, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of CHP+ members perspectives. Physicians could ask questions about parents'/caretakers' of CHP+ members concerns, priorities, and values and listen to their answers.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage parents/caretakers of CHP+ members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Exploring ways to direct parents/caretakers of CHP+ members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To follow up on recommendations related to the FY 2022–2023 CAHPS, DHMP reported engaging in the following QI initiatives:

- DHMP implemented a member experience committee, which met monthly to discuss all CAHPS categories and issues contributing to barriers across all LOBs.
- DHMP collaborated with Square ML, a machine learning vendor, to develop a comprehensive CAHPS dashboard. The initiative included automating processes to minimize the resources required for manual data manipulation and employing artificial intelligence (AI) technology to extract and categorize trends from member survey feedback. Upon development, DHMP stated that it plans to implement this solution across all LOBs.
- DHMP enhanced its website by adding a dedicated space where parents/caretakers of CHP+ members could inquire about claims and submit appeals, which ensured a more streamlined and efficient experience for parents/caretakers of CHP+ members.
- DHMP added access to care as a key performance indicator to its strategic plan for the upcoming three years. Additionally, the DHHA Access to Care Committee was tasked with enhancing access to care. DHMP reported it regularly communicated with the committee, provided weekly lists of members who were waitlisted and unable to secure timely visits, addressed those issues, and implemented necessary adjustments to appointment availability.

- DHMP provided high-level education regarding health plan CAHPS scores to clinics.
- To increase member outreach through ACS care support initiatives, DHMP focused on addressing gaps in care and promoting preventive health screenings. Over the last year, DHMP's care management team conducted outreach for well-child visits and maternity/postpartum care, successfully reaching 500 members. DHMP scheduled appointments for 196 members. Additionally, DHMP implemented three rounds of automated calls, with an average of 13,000 members contacted in each round. Those efforts were complemented by follow-up communications for medication adherence and chronic condition management, significantly enhancing its member engagement and support.
- DHMP implemented focused member outreach by having the DHMP care management team facilitate care transitions based on acuity of need. DHMP's ADT feed, which will allow care managers to target parents/caretakers of CHP+ members who are at high risk for readmissions and have preventable admissions, is being beta tested.
- DHMP added dental, family planning, and OB/GYN appointment types for scheduling via MyChart.
- DHMP offered extended hours on weeknights and Saturday appointments at multiple clinics.
- DHMP revamped the DHMP member resources section of its website. The new version made it easier for parents/caretakers of CHP+ 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.).

Assessment of DHMP's Approach to Addressing FY 2022–2023 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 2023, DHMP reported no investigated QOCGs. DHMP's average CHP+ membership in CY 2023 was 10,035, with 6,320 members enrolled as of December 31, 2023. DHMP delegated investigation of BH-related potential QOCCs and QOCGs to COA. Beginning May 31, 2023, COA began sending all PH-related concerns about DHMP members to DHMP for investigation.

DHMP: Strengths

DHMP submitted various policies and procedures outlining how DHMP handles QOCGs and QOCCs; however, HSAG was unable to determine strengths related to DHMP's QOCG and QOCC processes since no cases were reported during CY 2023.

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

HSAG found the following opportunities for improvement:

- Documents submitted by DHMP did not specifically address how DHMP defines a "QOCC" or a "QOCG."
- The *DHMP Member Handbook* included information about the process for filing a grievance; however, the handbook did not distinguish between a "member grievance" and a "QOCG."
- DHMP's *Quality of Care Complaints Job Aid* included the categories of findings (*Unsubstantiated*, *Substantiated*, and *Inconclusive*), but DHMP did not use a severity rating scale. Although the job aid included the categories, it did not include a definition for each determination nor address potential actions based on the finding categories.
- The submitted documents did not specifically address how DHMP is to follow up with the member to determine if the member's immediate healthcare needs are being met.
- The submitted documents did not address when DHMP is to notify the Department regarding a QOCG or submit a QOC summary as outlined in the CHP+ MCO contract.

To address these opportunities, HSAG recommends DHMP:

- Provide a guide for DHMP staff members outlining what would constitute a potential QOCG to ensure that all potential QOCGs are investigated.
- Update applicable documents to specifically define "QOCC" and "QOCG."
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Develop and update applicable documents and job aids to include the finding category definitions and provide potential actions based on the finding categories.
- Update its applicable policies and procedures to address how DHMP will follow up with the member to determine if the member's immediate healthcare needs are being met.
- Implement a process for notifying the Department that a QOC issue has been received and document the process for submitting a QOC summary to ensure compliance with the CHP+ MCO contract.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

In FY 2022–2023, HSAG recommended 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 QOCG/QOCC processes and create a clear policy or cohesive set of documents to describe DHMP's response to QOCGs and QOCCs.
- Develop written criteria, checklists, or examples of situations that would indicate a referral to the registered nurse (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 Denver Health and Hospital Authority (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 QOCG/QOCC training program for all staff members who may have a role in identifying, submitting for review, or investigating QOCGs and QOCCs.
- DHMP may want to consider clarifying policies and procedures with regard to reporting QOCGs and QOCCs to regulatory agencies and working with the Department to determine which regulatory agencies should receive reporting of QOCGs and QOCCs 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.

Review and Assessment of DHMP's Approach to Addressing FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

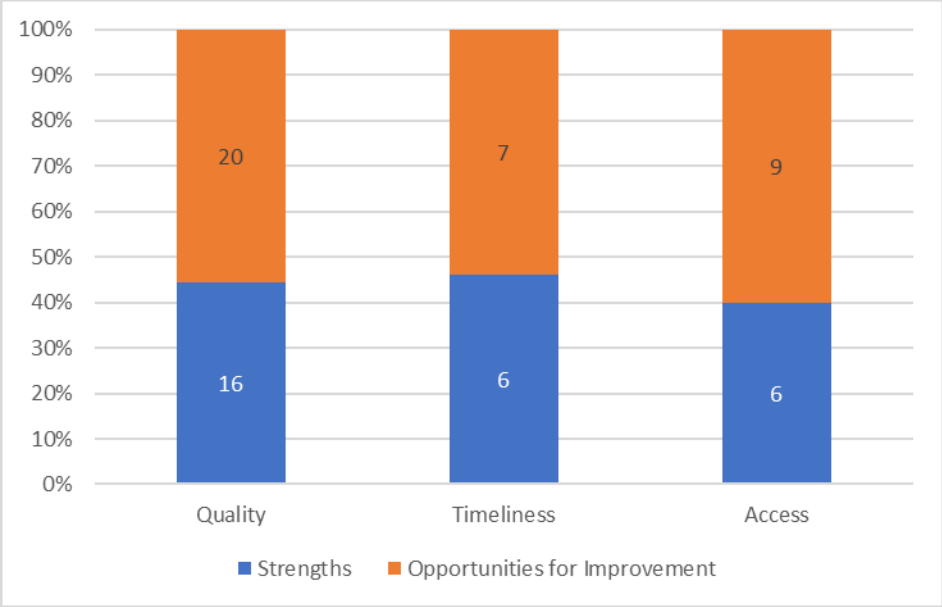
DHMP reported addressing HSAG's recommendations by:

- Reviewing policies and processes to ensure potential QOCGs are captured at all possible avenues (e.g., members, providers, medical record review).

Since DHMP continued to report that no QOCGs investigated during the FY 2023–2024 review period, HSAG determined that DHMP still has the opportunity to conduct a comprehensive audit of call center logs to assess how many calls may have included an expression of dissatisfaction and ensure any potential QOCGs are captured and routed to the correct DHMP or DHHA department for investigation. DHMP should continue addressing the recommendations and prepare for guidance from the Department for upcoming contractual changes and requirements.

Kaiser Permanente Colorado

Figure 4-3—Number of Strengths and Opportunities for Improvement by Care Domain for Kaiser*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

Kaiser submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Well-Child Visits [WCV]* PIP and the nonclinical *Social Determinants of Health [SDOH] Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. Kaiser resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 4-21 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *WCV*

Table 4-21—2023–2024 PIP Overall Confidence Levels for the *WCV* PIP

	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	83%	88%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *WCV* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. Kaiser received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening*

Table 4-22—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	83%	88%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. Kaiser received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *WCV*

Table 4-23 displays data for Kaiser's *WCV* PIP.

Table 4-23—Performance Indicator Results for the *WCV* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible CHP+ members who receive six or more well-child visits (Well-Care Value Set) on	N: 73	49.32%					

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
different dates of service on or before the 15-month birthday (if age <15 months), or two or more visits on or before the 30-month birthday (if ages 15–30 months).	D: 148						

N–Numerator D–Denominator

For the baseline measurement period, Kaiser reported that 49.32 percent of eligible CHP+ members received the required number of well-child visits during the measurement year.

Nonclinical PIP: *SDOH Screening*

Table 4-24 displays data for Kaiser's *SDOH Screening* PIP.

Table 4-24—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of CHP+ members with a complete SDOH questionnaire.	N: 1,080 D: 4,876	22.15%					

N–Numerator D– Denominator

For the baseline measurement period, Kaiser reported that 22.15 percent of CHP+ MCO members completed an SDOH questionnaire during the measurement year.

Interventions

Clinical PIP: *WCV*

Table 4-25 displays the barriers and interventions documented by the health plan for the *WCV* PIP.

Table 4-25—Barriers and Interventions for the *WCV* PIP

Barriers	Interventions
Incomplete parent/caregiver awareness that well visits are overdue	Expansion of automated reminders for parents/caregivers
Sub-optimal rates of awareness of actionable well visit care gaps among staff and providers interacting with members during acute care visits and other contacts	Distribution of well care gap reports to providers
Low rates of access to care gap information and scheduling tools in the patient portal	Promotion of patient portal registration for parents/caregivers

Nonclinical PIP: *SDOH Screening*

Table 4-26 displays the barriers and interventions documented by the health plan for the *SDOH Screening* PIP.

Table 4-26—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
Lack of screening opportunities for members not coming for the well visits	Expansion of screening beyond well visits
Difficulty reaching patients who do not access routine care	Expansion of screening to urgent care settings
Inability of some parents/caregivers to access pre-visit questionnaires on patient portal	Promotion of patient portal enrollment for parents/caregivers

Kaiser: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for Kaiser:

- Kaiser followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- Kaiser reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

Kaiser: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. Kaiser addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle and Kaiser received *High Confidence* for the final Module 4 submission. Kaiser's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2023 FAR, Kaiser 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 Kaiser's performance measure reporting.

Performance Measure Results

Table 4-27 shows the performance measure results for Kaiser for MY 2021 through MY 2023, along with the percentile rankings for each MY 2023 rate. Please note that this table presents performance measure rates reported using administrative methodology.

Table 4-27—Performance Measure Results for Kaiser

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Total	44.27%	42.70%	51.08%^	50th–74th
Childhood Immunization Status				
Combination 3	77.06%	67.71%	58.33%	10th–24th
Combination 7	69.72%	60.42%	55.21%	25th–49th
Combination 10	56.88%	47.92%	39.58%	75th–89th
Chlamydia Screening in Women				
16 to 20 Years	47.12%	38.61%	35.96%	<10th
Developmental Screening in the First Three Years of Life				
Total	NA	61.54%	73.33%^	BTSA

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Immunizations for Adolescents				
Combination 1	80.12%	79.58%	75.31%	25th–49th
Combination 2	42.47%	43.31%	40.74%	50th–74th
Lead Screening in Children				
Lead Screening in Children	NA	2.08%	9.47%^	<10th
Screening for Depression and Follow-Up Plan				
12 to 17 Years	NA	1.00%	2.83%	WTSA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	90.75%	90.56%	94.04%^	≥90th
Counseling for Nutrition—Total	92.77%	91.40%	93.99%	≥90th
Counseling for Physical Activity—Total	93.12%	91.75%	94.14%	≥90th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	16.67%	23.61%	50.00%^	10th–24th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	47.55%	64.20%	62.35%	25th–49th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years	NA	17.62%	17.93%	WTSA
LARC—15 to 20 Years	NA	4.13%	4.10%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days	NA	NA	NA	—
MMEC—15 to 20 Years—90 Days	NA	NA	NA	—
LARC—15 to 20 Years—3 Days	NA	NA	NA	—
LARC—15 to 20 Years—90 Days	NA	NA	NA	—
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—Under 21 Years	NA	NA	80.00%	BTSA
Postpartum Care—Under 21 Years	NA	NA	84.00%	BTSA
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years	91.18%	80.00%	NA	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years	NA	NA	100.00%	≥90th
Behavioral Health Care				
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years	NA	NA	NA	—

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	37.14%	54.84%	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	NA	NA	NA	—
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years	—	19.04	20.83	—

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.
— 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 that there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
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.

Kaiser: Strengths

The following HEDIS MY 2023 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 2022; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2022):

- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 10*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months to 17 Years*

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

The following HEDIS MY 2023 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 2022):

- *Childhood Immunization Status—Combination 3*
- *Chlamydia Screening in Women—16 to 20 Years*
- *Immunizations for Adolescents—Combination 1*
- *Lead Screening in Children*
- *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 *Chlamydia Screening in Women* measure, ensure providers are trained to address STI stigma and on how to discuss STI screenings with patients. Kaiser can mail a screening card reminder with information on regular women's health checkups such as pap smear and STI screenings. Kaiser could require lab results to be reported directly to Kaiser from network providers, in addition to usual reports sent to providers.[20]

[20] National Committee for Quality Assurance. *Improving Chlamydia Screening*. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on: Dec 5, 2024.

- For the *Lead Screening in Children* measure, consider ensuring comprehensive screening occurs across all network providers. Kaiser has the opportunity to work with providers to identify and address the factors contributing to the low rates for preventive screenings for children and adolescents (e.g., barriers to accessing care such as limited providers or transportation, provider billing issues, administrative data source challenges).
- For the *Childhood Immunization Status* and *Immunizations for Adolescents* measures, provide education to providers on the importance of integrating immunizations into well-child visits and sports physicals. HSAG also recommends Kaiser work with its providers to ensure they are recording vaccines patients may receive outside of provider care, such as through a pharmacy. Kaiser should also consider coordinating vaccine clinics in geographic areas with a high rate of members at convenient hours for families such as evenings or Saturdays.[21,22]
- For the *Well-Child Visits in the First 30 Months of Life* measure, work with its provider network to identify barriers to visits with this population as well as implement interventions that may help to overcome some of the barriers (e.g., member incentives such as gift cards and baby supplies, care management and parenting supports, transportation assistance).

Follow-Up on FY 2022–2023 HEDIS Measure Recommendations

FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG recommended 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 Kaiser 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 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 work groups designed to solicit best practices from other organizations within and/or outside the state.

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[21] Das JK, Salam RA, Arshad A, Lassi ZS, Bhutta ZA. Systematic Review and Meta-Analysis of Interventions to Improve Access and Coverage of Adolescent Immunizations. *J Adolesc Health*. 2016 Oct;59(4S):S40-S48. Available at: https://pubmed.ncbi.nlm.nih.gov/27664595/. Accessed on: Dec 5, 2024.

[22] American Academy of Pediatrics. *Adolescent Immunization Discussion Guides*. Available at: https://www.aap.org/en/patient-care/immunizations/adolescent-immunization-discussion-guides/. Accessed on: Dec 5, 2024.

- To ensure timely follow-up visits, consider leveraging the discharge planning process to facilitate scheduling each member's follow-up visit.

Assessment of Kaiser's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- Kaiser reported working on its CHP+ onboarding process, which includes a special focus on pregnant women. Kaiser reported it has been finding that pregnant CHP+ members have been assigned to Kaiser despite having already established care with non-Kaiser obstetrics (OB) providers. Kaiser reported it is looking into a data reporting issue to see if it can receive credit for network provider prenatal and postpartum visits.
- Kaiser stated that its Well Visit Workgroup has implemented an outreach campaign for members and care gap reminders for providers.
- For the *Lead Screening in Children* measure, Kaiser reported it expanded its care gap alert to providers to include CHP+.
- For the *Chlamydia Screening in Women* measure, Kaiser reported it is working on improving its onboarding process to better engage new members. Kaiser reported implementing a teen version of the care gap alert in spring 2023, and it is assessing these care gap alerts to see how it can best remind patients about screening.

HSAG recognizes that Kaiser's strategies aimed at improving its onboarding process for pregnant CHP+ members, its outreach campaigns around well-child visits, and care gap alerts for providers and members are likely to help improve and maintain performance rates.

Assessment of Compliance With CHIP Managed Care Regulations

Kaiser Overall Evaluation

Table 4-28 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 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-28—Summary of Kaiser Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information Requirements	21	21	18	3	0	0	86%˅
VII. Provider Selection and Program Integrity	16	15	15	0	0	1	100%^
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%~
X. QAPI, CPGs, and HIS	17	17	17	0	0	0	100%~
Totals	**58**	**57**	**53**	**4**	**0**	**1**	**93%***

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

^ *Indicates an increase from review three years prior.*

˅ *Indicates a decrease from review three years prior.*

~ *Indicates no change from review three years prior.*

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 (2019–2020, 2022–2023)	68%	88%
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	100%	100%
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	80%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	88%	60%

Standard and Applicable Review Years	Previous Review	Most Recent Review**
Standard V—Member Information Requirements (2020–2021, 2023–2024)*	**90%**	**86%**
Standard VI—Grievance and Appeal Systems (2020–2021, 2022–2023)	70%	71%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**100%**	**100%**
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**75%**	**75%**
Standard X—QAPI, CPGs, and HIS (2021–2022, 2023–2024)*	**100%**	**100%**
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*

***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: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, Kaiser demonstrated high-achieving scores for two out of four standards reviewed and for one standard a small decrease of 4 percentage points from the previous review cycle, indicating a moderate to strong overall understanding of the federal and State regulations. Three out of four standards' scores remained the same from the previous review cycle.

Kaiser: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG identified the following strengths for Kaiser:

- Kaiser followed a thorough provider selection and retention process, which included ongoing analysis of provider or specialist recruitment need, used multiple recruitment modalities, and used a detailed vetting process that aligns with NCQA guidelines and included a comprehensive onboarding process. 
- The compliance team's organizational structure was layered and included national, regional, and local compliance offices that work in conjunction with other departments to prevent, detect, and respond to compliance risks. In addition, documents outlined the compliance program in detail and were supported by policies, procedures, and a description of ongoing reports. 
- Reports submitted demonstrated overutilization monitoring and underutilization efforts, which included monitoring for gaps in care and a recently launched text messaging system that reminds parents of members in age-based cohorts to schedule well visits. 
- The claims processing workflow outlined how software was automated to identified issues such as data formatting errors, which would be sent back to the provider to address, or larger issues such as

extremely high-cost claims, which required additional handling, review, and approval from claims staff members before the claim could be further processed in the system.

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

HSAG found the following opportunities for improvement:

- The taglines in the provider directory portable document format (PDF) and the new member postcard did not include information on how to request auxiliary aids and services.
- Kaiser was inconsistent across several documents when describing the time frame required for sending a member requested information in paper form.
- Staff members could not convey how provider information was captured to ensure accuracy.
- One subcontractor agreement did not include federally required language.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Revise the provider directory PDF and the new member postcard taglines to describe how the member can request auxiliary aids and services.
- Update the desktop procedure, literature report procedure, and "how to order literature" process to be consistent with the time frame in the requirement.
- Develop a process to conduct outreach or other forms of communication with the provider to ensure that the information on the website's provider directory is up to date and accurate.
- Modify the agreement to include the required language and show an approved amendment.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended Kaiser:

- Edit the member handbook to include the complete definition of "medically necessary."
- Enhance monitoring procedures to ensure standard authorization decisions are made as expeditiously as required and do not exceed 10 calendar days. Update its policy to address the factors considered in expediting the decision and the notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Expedite authorization decisions when appropriate.
- Update its policies and procedures to address the exceptions to the 10-day notice required before the reduction, suspension, or termination of a previously authorized CHP+-covered service and should

either state that Kaiser does not deny previously authorized services (as recommended during the FY 2019–2020 review) or provide a process for doing so that includes federal and State requirements.

- Revise its policy to state that the attending emergency physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for coverage and payment.
- Make changes to its member handbook to state that with the member's written consent, a provider or authorized representative may file a grievance.
- Update its policies, procedures, and the member handbook to include providing member assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
- Revise the member handbook to state that the grievance acknowledgment letter will be sent within two working days.
- Make changes to the member handbook to state that the appeal acknowledgment letter will be sent within two working days.
- Update its policies and procedures to clarify that parties to an appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.
- Revise the member handbook to clarify that for standard appeals, Kaiser will provide the resolution notice within 10 working days from the day Kaiser receives the standard appeal.
- Update its policies and procedures to include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is a need for additional information and that the delay is in the member's interest.
- Edit the member handbook to inform the member that within two calendar days, Kaiser will give the member written notice of the reason for the delay and to inform the member of the right to file a grievance if the member disagrees with that decision. The member handbook must also state that Kaiser will resolve the appeal as expeditiously as the member's health condition requires and no later than the date that the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).
- Revise its member handbook and the CHP Appeal Rights document to state that the parties to the State fair hearing include the Contractor, the member and the member's representative, or the representative of a deceased member's estate.

Assessment of Kaiser's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, Kaiser updated multiple documents to include the member handbook, policies and procedures, and the CHP Appeal Rights document. In addition, Kaiser enhanced its monitoring procedures to ensure timeliness for authorization decisions. HSAG recognizes that updating inaccurate information through documents such as policies and procedures, and the CHP+ handbook, is likely to result in long-term improvements.

Validation of Network Adequacy

Kaiser: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for Kaiser:

- Kaiser met all minimum network requirements across all contracted counties for Adult, Family, and Pediatric Primary Care Practitioner (MD, DO, NP, CNS); both General and Pediatric Behavioral Health; General and Pediatric Psychiatrists and other Psychiatric Prescribers; and General SUD Treatment.
- Kaiser demonstrated strength in general specialty provider types, meeting the minimum network requirements for General Cardiology, General Gastroenterology, General Neurology, General Ophthalmology, General Orthopedics, General Otolaryngology/ENT, General Pulmonary Medicine, General Surgery and General Urology across all contracted counties.
- While Kaiser did not meet the minimum network requirements for all pediatric specialty provider types, the plan demonstrated greater than 98 percent access for each provider type where the plan failed to meet the standard, across all contracted counties.
- Kaiser had established a robust process to maintain the accuracy and completeness of provider information through its quarterly attestation reminders, which were sent to providers from its Medical Staff Office Web-based (MSOW) software system and quarterly provider directory attestation requirement, three-year cycle for credentialing and recredentialing process, and several Web crawls that were run by MSOW regularly, ensuring business continuity of the process.

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 Practitioner (PA) in any contracted county.
- Kaiser did not meet the minimum network requirement for Pharmacies and Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in 85.7 percent of contracted counties.
- Kaiser indicated that the 834 file that comes from the Department contains a pseudo address of "General Delivery" in the address field where a member's address is unknown. Although the impact identified was not determined to be significant, Kaiser was unable to provide HSAG with a clear process for how it captures updated demographic information and the system's capability to capture

updated demographic information. Kaiser confirmed the use of the 834 files as the source of truth for all member eligibility and demographic information.

- Kaiser received a validation rating of *No Confidence* for 49.3 percent of indicators during the FY 2023–2024 NAV ISCA assessment. HSAG observed that Kaiser is using a standard different than those set forth by the Department.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that 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.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that Kaiser:

- 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.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of Kaiser's Approach to Addressing FY 2022–2023 NAV Recommendations

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

- In response to the findings for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals, Kaiser reported that the plan would review further. Kaiser noted that per a previous investigation, this gap is due to not having enough inpatient psychology providers available to contract within the affected areas.

- Kaiser described that its CHP+ contract does not specify that network adequacy must be met for PCP PAs or OB/GYN PAs. Kaiser reported that the plan feels this requirement is not applicable. Kaiser reported closing deficiencies for Pharmacies and Pediatric Pulmonary Medicine. Kaiser reported that it would review gaps to determine if they are due to lack of providers or an inability to contract with providers in the affected area.

Based on the above response, Kaiser has worked to address the NAV and PDV recommendations from FY 2022–2023, and HSAG has determined that these activities may lead to improvements in member access to care.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

CAHPS Survey

Findings

Table 4-30 shows the general child results achieved by Kaiser for FY 2021–2022 through FY 2023–2024.

Table 4-30—General Child Results for Kaiser

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	60.56%	66.67%	62.11% ↓
Rating of All Health Care	68.31%	70.06%	67.55%
Rating of Personal Doctor	78.00%	75.92%	79.27%
Rating of Specialist Seen Most Often	69.39%+	71.70%+	67.57%+
Getting Needed Care	79.74%+	79.37%	78.52%+
Getting Care Quickly	80.36%+	84.07%	78.39% ↓
How Well Doctors Communicate	97.81%	93.51%	95.75%
Customer Service	85.25%+	84.67%+	84.29%+
Coordination of Care	88.00%+	90.28%+	81.82%+

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 2023–2024 score is statistically significantly higher than the 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present CHP+ health plan-level results in this report.

Kaiser: Strengths

The following measures' FY 2023–2024 scores for Kaiser were higher, although not statistically significantly, than the 2023 NCQA national averages and FY 2022–2023 scores:

- *Rating of Personal Doctor*
- *How Well Doctors Communicate*

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

The following measures' FY 2023–2024 scores for Kaiser were statistically significantly lower than the 2023 NCQA national averages:

- *Rating of Health Plan*
- *Getting Care Quickly*

The following measures' FY 2023–2024 scores for Kaiser were lower, although not statistically significantly, than the FY 2022–2023 scores:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Coordination of Care*

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

- Involving staff members at every level to assist in improving the member experience.
- Exploring any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with parents/caretakers of CHP+ members. Specialists could ask questions about parents'/caretakers' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the

actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.

- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Obtaining and analyzing parents'/caretakers' of CHP+ members experiences with timeliness in scheduling appointments; amount of time spent in waiting rooms/doctors' offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Obtaining feedback from parents/caretakers of CHP+ members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.
- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage parents/caretakers of CHP+ members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Exploring ways to direct parents/caretakers of CHP+ members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.

Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To follow up on recommendations related to the FY 2022–2023 CAHPS, Kaiser reported engaging in the following QI initiatives:

- Kaiser made updates to its onboarding process to better engage CHP+ members.
- Kaiser focused on improving KP.org enrollment rates, so parents/caretakers of CHP+ members can easily communicate with their child's providers via secure email, phone, chat, or in person.

Assessment of Kaiser's Approach to Addressing FY 2022–2023 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 2023, Kaiser received and investigated three potential QOCG cases. Kaiser's average CHP+ membership in CY 2023 was 11,682, with 6,524 members enrolled as of December 31, 2023. Of the three QOC cases investigated by Kaiser, none were substantiated.

Kaiser: Strengths

Based on QOCG and QOCC audit activities in FY 2023–2024, HSAG found the following strengths for Kaiser:

- In all three cases, Kaiser followed up with the members to ensure that their immediate health needs were being met.
- Kaiser submitted a QOC summary to the Department for each case reviewed, fulfilling the contract requirement for Department notification about receipt of a QOC issue.
- Kaiser provided a guide for the grievance and appeal staff members to use to identify which complaints warrant referral to a quality review coordinator (QRC) for review to determine if further investigation is needed. Additionally, Kaiser provided a checklist for QRCs to use to determine if a referral to a quality physician review is warranted. HSAG determined these to be best practices within Kaiser's processes.

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

HSAG found the following opportunities for improvement:

- Policies, procedures, and other documentation submitted by Kaiser described the process of a QRC, who is a registered nurse, reviewing the potential QOCG to determine if the case meets criteria for review by a quality physician or an ad hoc peer review committee; however, Kaiser did not provide evidence in the three cases submitted that a review by a QRC occurred.
- Policies and procedures did not specifically address how Kaiser is to follow up with the member to determine if the member's immediate healthcare needs are being met.
- The *Kaiser Permanente CHP+ Member Handbook* available on Kaiser's website included information about the process for filing a grievance, but the handbook did not distinguish between a "grievance" and a "QOCG."

To address these opportunities, HSAG recommends Kaiser:

- Follow established policies and procedures during the CY 2023 review period and ensure that the reviewers involved with reviewing the potential QOCG case have the indicated qualifications as outlined in its policies and procedures.
- Update applicable policies and procedures to address how Kaiser is to follow up with the member to determine if the member's immediate healthcare needs are being met.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

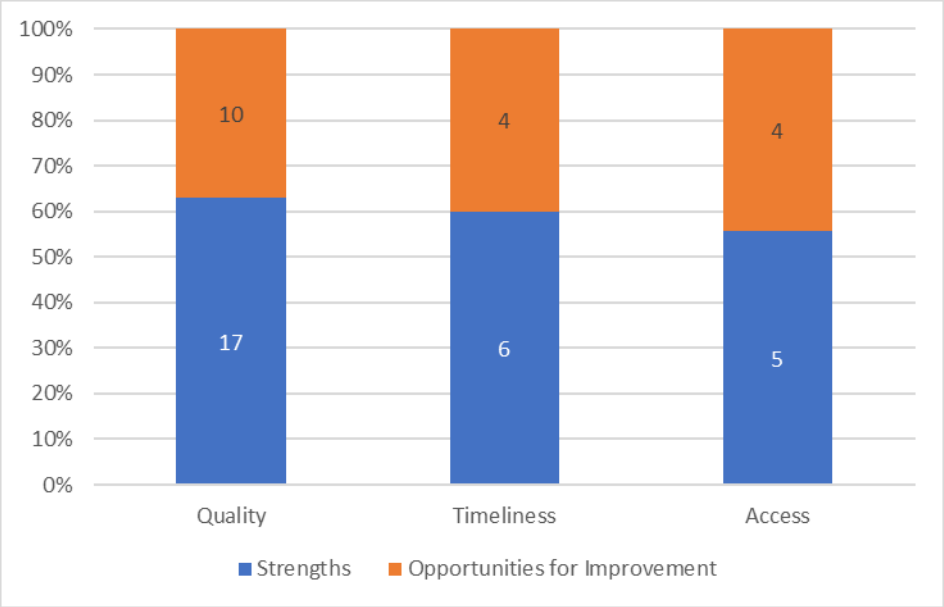
Kaiser did not have any opportunities for improvement that lead to recommendations during FY 2022–2023.

Review and Assessment of Kaiser's Approach to Addressing FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

Kaiser did not have any opportunities for improvement that led to recommendations and a response was not applicable. HSAG encourages Kaiser to work with the Department and prepare for guidance from the Department for upcoming contractual changes and requirements.

Rocky Mountain Health Plans

Figure 4-4—Number of Strengths and Opportunities for Improvement by Care Domain for RMHP*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

RMHP submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Well-Child Visit [WCV] Rates for RMHP CHP+ Members* PIP and the nonclinical *Improving the Rate of Social Determinants of Health [SDOH] Screening for CHP+ Members* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. RMHP resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 4-31 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *WCV Rates for RMHP CHP+ Members*

Table 4-31—2023–2024 PIP Overall Confidence Levels for the *WCV Rates for RMHP CHP+ Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
Resubmission	*Not Applicable*			*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *WCV Rates for RMHP CHP+ Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *Improving the Rate of SDOH Screening for CHP+ Members*

Table 4-32—2023–2024 PIP Overall Confidence Levels for the *Improving the Rate of SDOH Screening for CHP+ Members* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	67%	50%	*Low Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Improving the Rate of SDOH Screening for CHP+ Members* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. RMHP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Performance Indicator Results

Clinical PIP: *WCV Rates for RMHP CHP+ Members*

Table 4-33 displays data for RMHP's *WCV Rates for RMHP CHP+ Members* PIP.

Table 4-33—Performance Indicator Results for the *WCV Rates for RMHP CHP+ Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible CHP+ members ages 3 to 21 years who completed one or more well-care visits during the measurement year.	N: 2,513 D: 5,251	47.86%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP reported that 47.86 percent of eligible CHP+ members ages 3 to 21 years who completed one or more well-care visits during the measurement year.

Nonclinical PIP: *Improving the Rate of SDOH Screening for CHP+ Members*

Table 4-34 displays data for RMHP's *Improving the Rate of SDOH Screening for CHP+ Members* PIP.

Table 4-34—Performance Indicator Results for the *Improving the Rate of SDOH Screening for CHP+ Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible CHP+ members who had at least one billed encounter in the measurement year and who completed an SDOH screening.	N: 98 D: 6,160	1.59%					

N–Numerator D–Denominator

For the baseline measurement period, RMHP reported that 1.59 percent of eligible CHP+ members who had at least one billed encounter were screened for SDOH during the measurement year.

Interventions

Clinical PIP: *WCV Rates for RMHP CHP+ Members*

Table 4-35 displays the barriers and interventions documented by the health plan for the *WCV Rates for RMHP CHP+ Members* PIP.

Table 4-35—Barriers and Interventions for the *WCV Rates for RMHP CHP+ Members* PIP

Barriers	Interventions
• Lack of member understanding of the importance of a well-child visit • Lack of member motivation and activation to receive a well-child visit and establish care with a primary care provider	WCV Member Rewards Program to incentivize member/caregivers for completing a well-child visit
Difficulty accessing care, which includes establishing and scheduling WCVs with a primary care provider	Live member outreach calls to assist with scheduling the well-child visit

Nonclinical PIP: *Improving the Rate of SDOH Screening for CHP+ Members*

Table 4-36 displays the barriers and interventions documented by the health plan for the *Improving the Rate of SDOH Screening for CHP+ Members* PIP.

Table 4-36—Barriers and Interventions for the *Improving the Rate of SDOH Screening for CHP+ Members* PIP

Barriers	Interventions
• Less engagement from providers when work is not reimbursed • No code specifically set to reimburse screening for SDOH	Provider payment for SDOH screening of members
• High rates of staff turnover require periodic re-training • SDOH screening and intervening appropriately can lead to cumbersome workflows • Need for meaningful storage of SDOH data and communication of information across care teams	Provider coaching on effective and efficient SDOH screening practices

RMHP: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
- RMHP reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.

RMHP: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG did not identify any opportunities for improvement. RMHP addressed all validation criteria and received validation ratings of *High Confidence* for the clinical and nonclinical PIPs in FY 2023–2024.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle and RMHP received *High Confidence* for the final Module 4 submission. RMHP's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2023 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 4-37 shows the performance measure results for RMHP for MY 2021 through MY 2023, along with the percentile rankings for each MY 2023 rate. Please note that this table presents performance measure rates reported using administrative methodology, while performance measure rates reported using hybrid methodology are presented in Appendix A.

Table 4-37—Performance Measure Results for RMHP

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits				
Total	50.84%	47.14%	44.46%	25th–49th
Childhood Immunization Status				
Combination 3	52.00%	64.38%	64.42%	50th–74th
Combination 7	49.14%	61.64%	59.62%	50th–74th
Combination 10	42.86%	37.67%	37.50%	50th–74th
Chlamydia Screening in Women				
16 to 20 Years	35.05%	32.12%	28.04%	<10th
Developmental Screening in the First Three Years of Life				
Total	57.54%	58.87%	54.30%	WTSA
Immunizations for Adolescents				
Combination 1	68.90%	61.33%	64.73%	<10th
Combination 2	33.11%	22.43%	28.42%	10th–24th
Lead Screening in Children				
Lead Screening in Children	NA	35.37%	37.50%	10th–24th
Screening for Depression and Follow-Up Plan				
12 to 17 Years	6.81%	9.17%	10.12%	WTSA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	18.06%	20.36%	18.02%	<10th
Counseling for Nutrition—Total	27.26%	24.06%	24.57%	<10th
Counseling for Physical Activity—Total	14.26%	18.52%	20.43%	<10th
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	26.79%	41.18%	66.23%^	75th–89th
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	71.43%	70.00%	70.54%	50th–74th
Maternal and Perinatal Health				
Contraceptive Care—All Women				
MMEC—15 to 20 Years	24.39%	20.88%	22.42%	BTSA
LARC—15 to 20 Years	5.49%	4.52%	5.04%	BTSA
Contraceptive Care—Postpartum Women				
MMEC—15 to 20 Years—3 Days	NA	NA	NA	—
MMEC—15 to 20 Years—90 Days	NA	NA	NA	—
LARC—15 to 20 Years—3 Days	NA	NA	NA	—
LARC—15 to 20 Years—90 Days	NA	NA	NA	—

Performance Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—Under 21 Years	NA	NA	54.17%	WTSA
Postpartum Care—Under 21 Years	NA	NA	51.39%	WTSA
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
5 to 18 Years	82.50%	77.78%	NA	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
3 Months to 17 Years	NA	81.16%	87.10%	≥90th
Behavioral Health Care				
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—6 to 17 Years	NA	NA	NA	—
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
30-Day Follow-Up—13 to 17 Years	NA	NA	NA	—
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6 to 17 Years	35.48%	NA	NA	—
30-Day Follow-Up—6 to 17 Years	58.06%	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	40.91%	41.86%	59.38%	≥90th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	NA	NA	NA	—
Use of Services				
Ambulatory Care: ED Visits				
0 to 19 Years	—	17.45	16.76	—

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.
— 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 that there was no benchmark for comparison.
BTSA indicates the reported rate was better than the statewide average.
WTSA indicates the reported rate was worse than the statewide average.
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.

RMHP: Strengths

The following HEDIS MY 2023 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 2022; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2022):

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months to 17 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

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

The following HEDIS MY 2023 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 2022):

- *Chlamydia Screening in Women—16 to 20 Years*
- *Immunizations for Adolescents—Combination 1*
- *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*

To address these low rates, HSAG recommends RMHP:

- For the *Chlamydia Screening in Women* measure, ensure providers are trained to address STI stigma and on how to discuss STI screenings with patients. RMHP may consider mailing a screening card reminder with information on regular women's health checkups such as pap smear and STI screenings. In addition, HSAG recommends that RMHP track chlamydia screening rates and report provider-specific rates to physicians and large practices. RMHP could require lab results to be reported directly to RMHP from network providers, in addition to usual reports sent to providers.[23]
- For the *Lead Screening in Children* measure, consider ensuring comprehensive screening occurs across all network providers and working with providers to identify and address the factors

[23] National Committee for Quality Assurance. *Improving Chlamydia Screening*. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on: Dec 5, 2024.

contributing to the low rates for preventive screenings for children and adolescents (e.g., barriers to accessing care such as limited providers or transportation, provider billing issues, administrative data source challenges).

- For the *Immunizations for Adolescents* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, provide education to providers on the importance of integrating immunizations and weight assessment into well-child visits and sports physicals. HSAG recommends that RMHP create a provider report that indicates which members have care gaps in this area to help focus outreach for scheduling visits.
- For the *Immunizations for Adolescents* measure, work with its providers to ensure they are recording vaccines patients may receive outside of provider care, such as through a pharmacy. RMHP may also consider coordinating vaccine clinics in geographic areas with a high rate of members at convenient hours for families such as evenings or Saturdays.[24,25]

Follow-Up on FY 2022–2023 HEDIS Measure Recommendations

FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG recommended 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 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.

[24] Das JK, Salam RA, Arshad A, Lassi ZS, Bhutta ZA. Systematic Review and Meta-Analysis of Interventions to Improve Access and Coverage of Adolescent Immunizations. *J Adolesc Health*. 2016 Oct;59(4S):S40-S48. Available at: https://pubmed.ncbi.nlm.nih.gov/27664595/. Accessed on: Dec 5, 2024.

[25] American Academy of Pediatrics. *Adolescent Immunization Discussion Guides*. Available at: https://www.aap.org/en/patient-care/immunizations/adolescent-immunization-discussion-guides/. Accessed on: Dec 5, 2024.

Assessment of RMHP's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

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

- RMHP reported the use of multiple interventions aimed at pregnant members, including an outreach program to high-risk pregnant members; a partnership with WellHop and SimpliFed for expectant members to receive additional support during their pregnancies, postpartum period, and with breastfeeding, pumping, and/or formula feeding; a partnership with Empower Health to conduct interactive voice response (IVR) outreach for low-risk pregnant members to get them scheduled for prenatal and postpartum visits; production of an annual care management newsletter that included information on maternity support programs; and information posted on the RMHP website landing page regarding all maternity programs and supports available. Finally, RMHP reported that it arranged for a RAE PCMP to share its best practices for the *Prenatal and Postpartum Care* measure during the January 2024 Clinical Quality Improvement (CQI) Newsroom.
- RMHP used member outreach campaigns; monthly IVR and postcard mailing for members who are due for their 1-year-old well visits; IVR calls to close gaps in care for multiple measures; a welcome guide mailed to new members to provide education and recommendations regarding the importance of wellness visits; welcome calls to new enrollees, including warm transfer to PCPs for an appointment to provide education and promote annual well visits; and a monthly postcard mailing for adolescents who missed an immunization between ages 16 and 18 years.
- RMHP reported that it established an Integrated Quality Workgroup (IQWg) that focuses on interventions for the pediatric population.

HSAG recognizes that the comprehensive focus on maternity interventions, the many modes of member outreach, and the IQWg are likely to help improve and maintain performance rates.

Assessment of Compliance With CHIP Managed Care Regulations

RMHP Overall Evaluation

Table 4-38 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 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-38—Summary of RMHP Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information Requirements	21	21	21	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%^

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%~
X. QAPI, CPGs, and HIS	17	17	17	0	0	0	100%~
Totals	**58**	**58**	**57**	**1**	**0**	**0**	**98%***

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

^ Indicates an increase from review three years prior.

~ Indicates no change from review three years prior.

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 (2019–2020, 2022–2023)	91%	97%
Standard II—Adequate Capacity and Availability of Services (2019–2020, 2022–2023)	100%	93%
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	80%	100%
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	88%	100%
Standard V—Member Information Requirements (2020–2021, 2023–2024)*	**95%**	**100%**
Standard VI—Grievance and Appeal Systems (2020–2021, 2022–2023)	97%	94%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**94%**	**100%**
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**75%**	**75%**
Standard X—QAPI, CPGs, and HIS (2021–2022, 2023–2024)*	**100%**	**100%**
Standard XII—Enrollment and Disenrollment (2022–2023)	NA***	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*

***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: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, RMHP demonstrated 100 percent compliance for three out of the four standards reviewed. Two standards improved from the previous review cycle, indicating a strong understanding of most federal and State regulations.

RMHP: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG identified the following strengths for RMHP:

- The contract management process from procurement to execution of subcontractor agreements included monitoring of subcontractor agreements via routine reporting, joint operating committees, and dashboards.
- The QI plan included a comprehensive array of topics such as performance monitoring, UM, clinical safety, programming, delegation oversight, and file review.
- RMHP described efforts to support members in rural and frontier areas, such as providing hemoglobin A1c (HbA1c) and colon cancer testing kits that members can use at home, which lessens the inconvenience of driving to an office for an appointment.

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

HSAG found the following opportunities for improvement:

- Subcontractor agreements did not include required federal language.

To address these opportunities for improvement, HSAG recommends RMHP:

- Update subcontractor agreements to include specific federal required language.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended RMHP:

- Update its NABD template for the CHP+ LOB to remove all references to continuation of benefits.
- Revise 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.

- Revise its Appeals Policy and Procedure to specify that continuation of benefits is not applicable to CHP+ members.

Assessment of RMHP's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, RMHP updated multiple documents to include the CHP+ member handbook, policies, and procedures, and the NABD template. HSAG recognizes that updating inaccurate information throughout documents, such as policies and procedures, the NABD template, and the CHP+ handbook, is likely to result in long-term improvements.

Validation of Network Adequacy

RMHP: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for RMHP:

- RMHP CHP+ performed well within the BH network category, meeting all minimum network requirements for Pediatric Behavioral Health, Pediatric Psychiatrists and other Psychiatric Prescribers, and Pediatric SUD Treatment in all contracted counties. Additionally, for General Behavioral Health, General Psychiatrists and other Psychiatric Prescribers, and General SUD Treatment, RMHP CHP+ met the minimum requirements in greater than 90 percent of all contracted counties. 
- RMHP CHP+ met the minimum network requirements for Family Practitioner (MD, DO, NP, CNS) and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) across all contracted counties. Additionally, RMHP CHP+ met the minimum network requirement for Adult Primary Care Practitioner (MD, DO, NP, CNS) in greater than 90 percent of all contracted counties. 
- RMHP CHP+ met the minimum network requirements for the following specialty provider categories in 90 percent or more of all contracted counties: General Behavioral Health, General and Pediatric Cardiology, General and Pediatric Ophthalmology, General and Pediatric Orthopedics, General Otolaryngology/ENT, General Pulmonary Medicine, General Surgery, and General Urology. 
- RMHP had established robust processes to research daily and monthly missing or incomplete data from the 834 file, which included its capture of the data on the daily fall-out reports, and manual validation and oversight by the RMHP processors for reconciliation. RMHP verified the accuracy of all data received through validation checkpoints. RMHP had strong data security, and annual testing was completed. 

- RMHP offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via My Practice Profile (MPP), Inbound Demographic Change Line, Roster Processing, and CAQH ProView.

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

HSAG found the following opportunities for improvement:

- RMHP CHP+ did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for any contracted counties.
- RMHP CHP+ did not meet the minimum network requirements for Gynecology, OB/GYN (PA) in greater than 95 percent of all contracted counties.
- RMHP CHP+ did not meet minimum network requirements for a number of specialty provider categories across contracted counties. For example, RMHP CHP+ did not meet minimum network requirements for Pediatric Endocrinology in 59.1 percent of all contracted counties, nor for General Endocrinology in 31.8 percent of all contracted counties.
- No ISCA-specific opportunities were identified.

To address these opportunities for improvement, HSAG recommends RMHP:

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that 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.

As part of the PDV activity conducted in FY 2022–2023, HSAG recommended that RMHP:

- 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.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of RMHP's Approach to Addressing FY 2022–2023 NAV Recommendations

In response to HSAG's recommendations, RMHP reported taking the following actions:

- RMHP maintained an open network policy for all providers within its service areas who met its credentialling 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 nurse practitioner staff member in an endocrinology practice in Mesa County, which is a net gain in access.
- RMHP continued to expand its pilot projects for e-consults, which provides PCP access to specialist consultations with providers outside their immediate area, and in some cases outside of the RMHP service area.
- RMHP continued the distribution of quarterly mailings to providers. This mailing asked providers to visit the website and attest, by signing a form, whether all information was correct. Or, if inaccuracies existed, to provide RMHP with the updated information.

Based on the above response, RMHP worked to address the NAV and PDV recommendations from FY 2022–2023. 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 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

CAHPS Survey

Findings

Table 4-40 shows the general child results achieved by RMHP for FY 2021–2022 through FY 2023–2024.

Table 4-40—General Child Results for RMHP

Measure	FY 2021–2022 Score	FY 2022–2023 Score	FY 2023–2024 Score
Rating of Health Plan	70.67%	67.90%	62.50% ↓
Rating of All Health Care	66.51%	68.07%	57.97% ↓
Rating of Personal Doctor	73.43%	71.76%	65.24% ↓
Rating of Specialist Seen Most Often	76.92%+	76.67%+	82.22%+
Getting Needed Care	88.69%	87.18%	78.99%+
Getting Care Quickly	93.38%	91.52%	88.96%
How Well Doctors Communicate	95.53%	96.73%	92.75%
Customer Service	89.83%+	86.75%+	85.32%+
Coordination of Care	78.95%+	83.53%+	80.77%+

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 2023–2024 score is statistically significantly higher than the 2023 NCQA national average.*

↓ *Indicates the FY 2023–2024 score is statistically significantly lower than the 2023 NCQA national average.*

▲ *Indicates the FY 2023–2024 score is statistically significantly higher than the FY 2022–2023 score.*

▼ *Indicates the FY 2023–2024 score is statistically significantly lower than the FY 2022–2023 score.*

Due to a low number of respondents for the CCC population, HSAG is unable to present CHP+ health plan-level results in this report.

RMHP: Strengths

The following measures' FY 2023–2024 scores for RMHP were higher, although not statistically significantly, than the 2023 NCQA national averages:

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

The following measure's FY 2023–2024 score for RMHP was higher, although not statistically significantly, than the FY 2022–2023 score:

- *Rating of Specialist Seen Most Often*

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

The following measures' FY 2023–2024 scores for RMHP were statistically significantly lower than the 2023 NCQA national averages:

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

The FY 2023–2024 scores for RMHP were lower, although not statistically significantly, than the FY 2022–2023 scores for every measure except *Rating of Specialist Seen Most Often*.

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

- Involving staff members at every level to assist in improving the member experience.
- Exploring any barriers to receiving timely care from specialists that may result in lower levels of experience.
- Providing specialists with brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way they communicate and interact with parents/caretakers of CHP+ members. Specialists could ask questions about parents'/caretakers' concerns, priorities, and values and listen to their answers. Specialists could check for understanding, while reinforcing key messages, by allowing parents/caretakers to repeat back what they understand about their child's condition and the actions they will take to monitor and manage the child's condition in the future, as well as follow up with any concerns that parents/caretakers might have about their child's healthcare.
- Implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.
- Obtaining and analyzing parents'/caretakers' of CHP+ members experiences with timeliness in scheduling appointments; amount of time spent in waiting rooms/doctors' offices; and turnaround times for diagnostic tests, results, and scheduling with other specialties.
- Focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on parents'/caretakers' of CHP+ members experiences, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of parents'/caretakers' of CHP+ members perspectives. Physicians could ask questions about parents'/caretakers' of CHP+ members concerns, priorities, and values and listen to their answers.
- Obtaining feedback from parents/caretakers of CHP+ members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.

- Exploring customer service recovery methods by identifying and resolving dissatisfaction in customer or clinical services. Service recovery actions can range from simply listening to the upset parent/caretaker, providing solutions, or making amends for problems that the parent/caretaker reported. To properly handle customer complaints, the following protocols could be implemented: (1) design unique ways to encourage parents/caretakers of CHP+ members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.
- Exploring ways to direct parents/caretakers of CHP+ members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information.

Conduct Follow-Up on FY 2022–2023 CAHPS Recommendations

FY 2022–2023 CAHPS Recommendations

To follow up on recommendations related to the FY 2022–2023 CAHPS, RMHP reported engaging in the following QI initiatives:

- The RMHP member-facing team notified provider advocates and the Value Based Contract Review Committee (VBCRC) when a healthcare provider was not accepting new patients or were requiring applications for acceptance. Provider advocates followed up with the provider offices to investigate and address parent/caretaker of CHP+ member concerns when appropriate. The care management director, a member of the VBCRC, followed up directly with parents/caretakers of CHP+ members when needed. VBCRC tracked these actions to evaluate objectively whether the practices were meeting the openness to Medicaid requirements outlined in their value-based contracts.
- RMHP reported that during member welcome calls, customer service staff members educated the parents/caretakers of CHP+ members on the importance of having a relationship with a PCP. Customer service staff members asked the parent/caretaker whether the CHP+ member had a PCP. If the member did have a PCP, customer service inquired if the member had an upcoming appointment. If the member did not have a PCP, customer service offered to help the parent/caretaker find one and connected them with the office to schedule an appointment.
- During assessments with parents/caretakers of CHP+ members, RMHP care coordinators asked parents/caretakers whether the CHP+ member had a PCP or other provider and inquired about upcoming appointments. If the parent/caretaker needed assistance finding a provider, the care coordinator supplied information and assisted parents/caretakers of CHP+ members in scheduling appointments.
- In the last year, RMHP gave CirrusMD, a telehealth platform for parents/caretakers of CHP+ members to access clinicians in real time, more promotion in member mailers and emails, as a QR code in existing mailers, and in business cards distributed by care coordinators and external stakeholders.

- The RMHP newsletters, learning collaborative events, and webinar series included articles about member experience topics such as training on leadership, BH skills, and care management.
- Cultural competency training was provided to providers who attended the health equity, care management, and BH skills training sessions.
- RMHP expanded the eConsult program in Mesa County. The goal of this program was to enable primary care clinicians to send consults to specialists via a designated platform designed with the primary care patient in mind. The eConsult platform sends appropriate referrals, supports general satisfaction with providers due to reducing 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 2022–2023 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 2023, RMHP investigated three potential QOCG cases. RMHP originally reported receiving eight QOC cases during CY 2023; however, during the record review it was discovered that several cases were incorrectly attributed to CHP+. In the post-interview follow-up, RMHP confirmed that the CHP+ plan received three potential cases, only two of which were included in the record review for this audit. RMHP's average CHP+ membership in CY 2023 was 13,276, with 8,786 members enrolled as of December 31, 2023. Of the two QOCG cases submitted by RMHP, one case was substantiated.

RMHP: Strengths

Based on QOCG and QOCC audit activities in FY 2023–2024, HSAG found the following strengths for RMHP:

- The *RMHP CHP+ Member Handbook* and RMHP's website included information about the process for filing a grievance. The handbook included a discussion about QOCGs and filing a grievance if a member has a QOCG. The handbook defined "quality of care" as when the "health care services you received meet medical standards and are likely to improve your health."
- When investigating a potential QOCG, RMHP staff members explained how RMHP not only investigates the issue reported, but also other issues identified within the member record, if any.
- RMHP's policy requires the medical director to review any potential *Level 2* or *Level 3* cases. RMHP staff members explained that, due to an increase in volume and severity of QOCCs from a large provider, they have been sending every BH potential QOC to the medical director for review.

This was noted to be a temporary change made to provide support, training, and oversight for providers.

- RMHP provided the Department with a monthly QOCG closed cases report, which fulfilled its contract requirement of notifying the Department of a QOCG and sending a QOC summary.

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

HSAG found the following opportunities for improvement:

- Although RMHP's policies and procedures described how QOCGs are screened for imminent threat to patient safety, they did not discuss how RMHP will follow up with the member to determine if the member's immediate healthcare needs are being met.
- RMHP's policies and procedures did not describe case-specific reporting to the Department when RMHP receives a potential QOCG or submits a QOC summary to the Department as detailed in the CHP+ MCO contract.

To address these opportunities, HSAG recommends RMHP:

- Update its applicable policies and procedures to include member outreach for all potential QOCGs to ensure that the member's immediate healthcare needs are being met as required in the CHP+ MCO contract.
- Update its applicable policies and procedures to address the process for notifying the Department when a QOC has been received as well as its process for submitting a QOC summary to ensure compliance with the CHP+ MCO contract.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

In FY 2022–2023, HSAG recommended 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 QOCGs may need additional detail.
- Develop a training for all staff members who may identify QOCG issues and who review and investigate the potential QOCGs or QOCCs. 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.

Review and Assessment of RMHP's Approach to Addressing FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

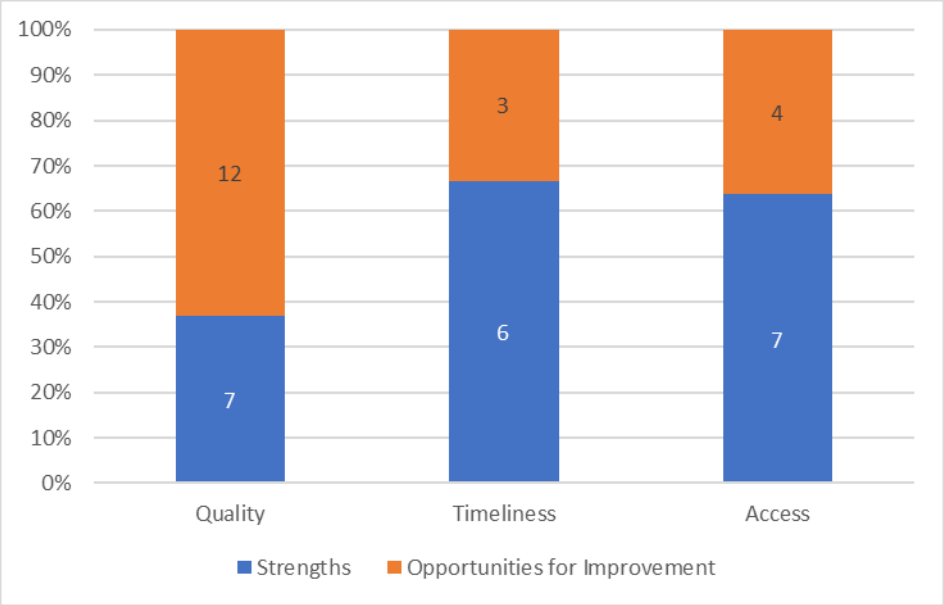
RMHP reported addressing HSAG's recommendations by:

- Updating and finalizing policies and procedures for the QOCG process to include use of United Health Care (UHC) concurrent and retrospective QOCG nurses and the Regional Peer Review Committee. Additionally, having protocols in place to appropriately route complaints/grievances to the quality team when care concerns are involved.
- Determining severity levels in all investigations and providers receiving a resolution letter for all *Level 2* and *Level 3* investigations.
- Sending monthly closed case lists to the Department to provide visibility into all cases and providing alerts in real time for escalated concerns. Additionally, the RMHP chief medical officer (CMO) is involved in all reporting, ensuring proper escalation of cases.

HSAG anticipates RMHP's response to the recommendations are likely to improve overall processes and increase compliance. RMHP should continue addressing the recommendations made by HSAG for continuous improvement and staff training. Additionally, RMHP should prepare for guidance from the Department for upcoming contractual changes and requirements.

DentaQuest

Figure 4-5—Number of Strengths and Opportunities for Improvement by Care Domain for DentaQuest*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Status

DentaQuest submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the clinical *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP and the nonclinical *Social Determinants of Health [SDOH] Screening—Member Survey* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. DentaQuest resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for the *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP and a *Low Confidence* level for the *SDOH Screening—Member Survey* PIP after the resubmission. Table 4-41 illustrates the initial submission and resubmission validation scores for each PIP.

Clinical PIP: *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations*

Table 4-41—2023–2024 PIP Overall Confidence Levels for the *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	33%	25%	*No Confidence*	*Not Assessed*		
Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DentaQuest received *Met* scores for 100 percent of

applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

Nonclinical PIP: *SDOH Screening—Member Survey*

Table 4-42—2023–2024 PIP Overall Confidence Levels for the *SDOH Screening—Member Survey* PIP

Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Initial Submission	23%	25%	*No Confidence*	*Not Assessed*		
Resubmission	85%	88%	*Low Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *SDOH Screening—Member Survey* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *Low Confidence* level for adhering to acceptable PIP methodology. DentaQuest received *Met* scores for 85 percent of applicable evaluation elements in the Design and Implementation stages of the PIP. In the final PIP Validation Tool, DentaQuest received a *Partially Met* score for one critical evaluation element in Step 6—Data Collection Procedures, which resulted in a *Low Confidence* level. For this evaluation element, HSAG provided feedback to DentaQuest on the documented data collection process, recommending that the health plan explore alternative data collection methods for the SDOH screening performance indicator that would allow survey responses to be tracked and counted with a unique identifier. HSAG and the Department provided follow-up technical assistance to DentaQuest regarding the data collection methods for the *SDOH Screening—Member Survey* PIP after this year's validation was completed.

Performance Indicator Results

Clinical PIP: *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations*

Table 4-43 displays data for DentaQuest's *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP.

Table 4-43—Performance Indicator Results for the *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of eligible enrollees under age 21 years that received at least one oral evaluation dental service during the measurement year.	N: 16,865 D: 44,006	38.32%					

N–Numerator D–Denominator

For the baseline measurement period, DentaQuest reported that 38.32 percent of eligible enrollees under age 21 years received at least one oral evaluation dental service during the measurement year.

Nonclinical PIP: *SDOH Screening—Member Survey*

Table 4-44 displays data for DentaQuest's *SDOH Screening—Member Survey* PIP.

Table 4-44—Performance Indicator Results for the *SDOH Screening—Member Survey* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of enrollees who completed the SDOH member survey during the measurement period.	N: 0 D: 45,435	0%					

N–Numerator D–Denominator

For the baseline measurement period, DentaQuest reported that 0 percent of enrollees completed the SDOH member survey during the measurement year.

Interventions

Clinical PIP: *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations*

Table 4-45 displays the barriers and interventions documented by the health plan for the *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP.

Table 4-45—Barriers and Interventions for the *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP

Barriers	Interventions
Low oral health literacy: parents/caregivers are unaware of the importance of preventive care and oral evaluation	Telephonic and/or mail outreach to enrollee/caregiver to educate them on the importance of preventive care and oral evaluation
Lack of provider awareness that member is overdue for dental visit to complete the oral evaluation	Provide reminder via phone and/or mail to schedule dental visit and complete annual oral evaluation
Low perceived need for oral evaluation; enrollee caregiver does not prioritize preventive dental care	Help enrollees/caregivers schedule appointment
	Provide incentive to motivate enrollees/caregivers to schedule dental visit and obtain oral evaluation
Enrollees/caregivers are unable to identify and access a provider that offers after-hours care	Identify providers who offer after-hours and weekend care and post on website
Misinformation and lack of trust of dental and healthcare providers	Cultural Ambassador Program: Train community organizations on the importance of oral health and preventive visits to share with communities they support

Nonclinical PIP: *SDOH Screening—Member Survey*

Table 4-46 displays the barriers and interventions documented by the health plan for the *SDOH Screening —Member Survey* PIP.

Table 4-46—Barriers and Interventions for the *SDOH Screening—Member Survey* PIP

Barriers	Interventions
• Low oral health literacy: enrollee/caregiver is unaware they have access to resources to address various SDOH • Enrollee/caregiver is unaware that SDOH survey is available and provides resources upon completion of survey	Outreach to members by phone and/or mail and/or portal alert educating them on the SDOH survey and benefit in completing survey

Barriers	Interventions
Enrollee/caregiver does not want to admit that they need assistance or help with SDOH (stigma)	Message on portal and in outreach education to empower members to obtain resources to address identified SDOH
Enrollee/caregiver fear of submitting SDOH survey responses and lack of privacy	Message on portal and in outreach education emphasizing and providing reassurance that responses are anonymous and not traceable to member
Misinformation and lack of trust of dental and healthcare providers	Cultural Ambassador Program: Train community organizations to reinforce importance of taking advantage of available resources and trust that responses are anonymous to share with communities they support

DentaQuest: Strengths Related to Validation of Performance Improvement Projects

Based on PIP validation activities conducted in FY 2023–2024, HSAG found the following strengths for DentaQuest:

- DentaQuest followed a methodologically sound design for the clinical *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP that facilitated valid and reliable measurement of objective indicator performance over time.
- DentaQuest reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical *Increasing the Rate of Enrollees Accessing Preventative Dental Services—Oral Evaluations* PIP.

DentaQuest: Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

HSAG found the following opportunities for improvement:

- DentaQuest's documented data collection process for the nonclinical *SDOH Screening—Member Survey* PIP did not clearly demonstrate that accurate, reliable, and meaningful performance indicator data could be produced for monitoring improvement in indicator results for the duration of the project.

To address the opportunities for improvement and to support a successful improvement project, HSAG recommends that DentaQuest:

- Apply technical assistance received from HSAG and the Department to improve the data collection process for the nonclinical *SDOH Screening—Member Survey* PIP, ensuring the process will produce methodologically sound and meaningful indicator results for evaluating improvement.

DentaQuest should update the data collection process for the PIP prior to next year's annual validation.

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The RAE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Follow-Up on FY 2022–2023 PIP Recommendations

FY 2022–2023 was the last year of the previous PIP cycle and DentaQuest received *High Confidence* for the final Module 4 submission. DentaQuest's Module 4 submission addressed all validation criteria, and no opportunities for improvement were identified. Follow-up on the prior year's PIP recommendations is not applicable.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the HEDIS MY 2023 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 4-47 shows the performance measure results for DentaQuest for MY 2021 through MY 2023, along with the percentile rankings for each MY 2023 rate.

Table 4-47—Performance Measure Results for DentaQuest

Performance Measure	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate	Percentile Ranking
Dental and Oral Health Services				
Oral Evaluation, Dental Services				
<1 Year	—	3.85%	3.68%	—
1 to 2 Years	—	24.60%	25.37%	—
3 to 5 Years	—	38.64%	39.40%	—
6 to 7 Years	—	44.73%	45.76%	—
8 to 9 Years	—	45.51%	45.25%	—
10 to 11 Years	—	43.72%	45.45%	—
12 to 14 Years	—	41.78%	41.67%	—
15 to 18 Years	—	32.58%	33.16%	—
19 to 20 Years	—	22.83%	21.53%	—
Total	—	38.25%	38.61%	—
Sealant Receipt on Permanent First Molars				
At Least One Sealant	24.49%	43.06%	54.28%	—
All Four Molars Sealed	14.30%	29.27%	40.60%	—
Topical Fluoride for Children				
Dental Services—1 to 2 Years	—	21.39%	19.31%	—
Dental Services—3 to 5 Years	—	26.41%	24.63%	—
Dental Services—6 to 7 Years	—	28.90%	25.17%	—
Dental Services—8 to 9 Years	—	30.16%	26.49%	—
Dental Services—10 to 11 Years	—	28.06%	24.47%	—
Dental Services—12 to 14 Years	—	24.04%	21.41%	—
Dental Services—15 to 18 Years	—	17.67%	15.87%	—
Dental Services—19 to 20 Years	—	7.14%	4.91%	—
Dental Services—Total	—	24.19%	21.37%	—

— 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 that there was no benchmark for comparison.

DentaQuest: Strengths

The following MY 2023 measure rates demonstrated improvement relative to the prior year, however, have no established benchmarks:

- *Sealant Receipt on Permanent First Molars—At Least One Sealant* and *All Four Sealed by the 10th Birthdate* 

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

Reported rates for DentaQuest could not be compared to national benchmarks because there were no established benchmarks for comparison; therefore, HSAG was not able to draw formal conclusions regarding performance based on MY 2023 reported results. Nonetheless, the DentaQuest results provide additional information that may be used to assess QI interventions.

Follow-Up on FY 2022–2023 HEDIS Measure Recommendations

FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG did not identify any opportunities for improvement for DentaQuest as it was the first year the measures were reported.

Assessment of DentaQuest's Approach to Addressing FY 2022–2023 HEDIS Measure Recommendations

In FY 2022–2023, HSAG did not identify any opportunities for improvement for DentaQuest as it was the first year the measures were reported. 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 4-48 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 2023–2024. No record reviews were conducted in FY 2023–2024.

Table 4-48—Summary of DentaQuest Scores for the FY 2023–2024 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	20	18	16	2	0	2	89%^
VII. Provider Selection and Program Integrity	16	15	13	2	0	1	87%~
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%~
X. QAPI, CPGs, and HIS	16	16	13	3	0	0	81%^
Totals	**56**	**53**	**46**	**7**	**0**	**3**	**87%***

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

^ Indicates an increase from review three years prior.

~ Indicates no change from review three years prior.

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 and Applicable Review Years	Previous Review	Most Recent Review**
Standard V—Member Information Requirements (2020–2021, 2023–2024)*	**63%**	**89%**
Standard VI—Grievance and Appeal Systems (2020–2021, 2022–2023)	74%	58%
Standard VII—Provider Selection and Program Integrity (2020–2021, 2023–2024)*	**87%**	**87%**
Standard VIII—Credentialing and Recredentialing (2021–2022)	NA***	100%
Standard IX—Subcontractual Relationships and Delegation (2020–2021, 2023–2024)*	**100%**	**100%**
Standard X—QAPI, CPGs, and HIS (2021–2022, 2023–2024)*	**50%**	**81%**
Standard XII—Enrollment and Disenrollment (2022–2023)	NA****	100%

**Bold text indicates standards reviewed by HSAG during FY 2023–2024.*

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

*****NA: Standard XII—Enrollment and Disenrollment was first reviewed in FY 2022–2023.*

In FY 2023–2024, DentaQuest demonstrated moderate to high achieving scores in all four standards, indicating improvement from the previous review cycle. One standard remained the same from the previous review cycle, indicating a strong understanding of most federal and State regulations.

DentaQuest: Strengths

Based on the four standards reviewed in FY 2023–2024, HSAG identified the following strengths for DentaQuest:

- DentaQuest had a detailed process to provide member information to members during their initial enrollment, as well as when requested, at no cost, in English and prevalent non-English languages and in alternative formats.
- DentaQuest ensured the accuracy of its provider directory by conducting semiannual outreach to the provider to update their information.
- DentaQuest routinely monitored subcontracted delegates through the use of "scorecards" that rated performance, engagement, communication, innovation, and an overall risk level.

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

HSAG found the following opportunities for improvement:

- The member handbook did not consistently include plain language, easy to understand language, and all required member rights content.
- DentaQuest's provider retention process was not documented within its written policies.
- DentaQuest did not include details regarding how to report fraud, waste, and abuse in its policy.
- The Quality Improvement Evaluation lacked an assessment of QAPI activities.
- DentaQuest did not include CPGs as defined by CMS or a mechanism to disseminate updates regarding CPGs to the provider network.

To address these opportunities for improvement, HSAG recommends DentaQuest:

- Review the entire member handbook to identify language that is not easy to understand and then implement changes necessary to use plain language and a format that is easy to follow.
- Update the member handbook to include the member's right to be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services.
- Document its provider retention process within its written policies.
- Revise its policies to include language pertaining to reporting waste and abuse and to protecting whistleblowers.
- Develop a more robust QAPI evaluation that includes all key components of the QAPI program, including an assessment of each QAPI activity.
- Develop a distinct list of CPGs for review and approval by the Peer Review Committee that are separate from UM criteria. Disseminate its CPGs to all affected providers.

Follow-Up on FY 2022–2023 Compliance Recommendations

FY 2022–2023 Compliance Recommendations

In FY 2022–2023, HSAG recommended DentaQuest:

- Update the UM Authorization Review policy and procedure to include authorization time frames.
- Revise denial service codes and clinical explanation located in the NABD to be in an easy-to-understand explanation.
- Amend policies, procedures, and NABD templates to explain all required details.

- Update policies and procedures to include the process and time frame for mailing the standard, expedited, and extended notices.
- Modify its policies and procedures to include the requirement that gives notice on or before the intended effective date of the proposed adverse benefit determination.
- 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.
- Update and monitor internal reports and associated procedures to include the correct time and distance standards for general and pediatric dentists in urban, rural, and frontier counties.
- Enhance its cultural competency program.
- 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 for tracking and trending purposes.
- Revise its policies and procedures to state that providers or member representatives may file a State fair hearing request on behalf of the member with the member's written consent and the CHP+ member handbook to describe how DentaQuest gives members reasonable assistance in completing any forms and taking other procedural steps related to grievances or appeals.
- Enhance its process to document in appeal case files that the reviewer has the appropriate clinical expertise.
- Enhance its procedures to send the member a written acknowledgement of each grievance within two working days of receipt and implement an ongoing process to monitor that the timelines are met.
- Enhance its procedures to resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance and update its acknowledgement letter to include the correct time frames.
- Amend and implement its policies, procedures, member handbook, and NABD templates to state that the member may file an appeal either orally or in writing and not require oral requests for an appeal to be followed with a written request.
- Enhance its procedures to send a written acknowledgement of each appeal within two working days of receipt and update member-facing communications to be consistent with the two working day timeline.
- Modify its policies and procedures to remove language regarding delegating expedited appeal notices to providers.
- Update related policies, procedures, and member communications to include the member's right to a prompt oral notice and the right to file a grievance if the request to expedite the appeal resolution is denied.
- Revise related policies, procedures, and member communications to include the correct time frame for appeal resolutions.

- Update its policies and procedures to ensure privacy rules are followed and do not include a process to delegate member notice requirements to providers or provider representatives, and implement processes to ensure that notices of an expedited resolution are not left on member voicemails.
- Correct its policies, procedures, monitoring practices, and member communications to ensure its process to: (1) make a reasonable effort to give the member prompt oral notice of the delay or need for an extension, and (2) provide written notice within two calendar days and describe the process used to resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
- Amend the Office Reference Manual (ORM) to include grievance time frames and inform the member of the availability of assistance in the grievance process.

Assessment of DentaQuest's Approach to Addressing FY 2022–2023 Compliance Recommendations

As part of the FY 2022–2023 CAP, DentaQuest updated multiple documents to include the ORM, policies, and procedures, and the NABD template. Additionally, DentaQuest enhanced processes to document the clinical reviewer's appropriate clinical expertise in the member appeal files. HSAG recognizes that updating inaccurate information throughout documents, such as policies and procedures, the NABD template, and the ORM, in addition to enhancing processes, is likely to result in long-term improvements.

Validation of Network Adequacy

DentaQuest: Strengths

Based on time and distance analysis and ISCA activities conducted in FY 2023–2024, HSAG found the following strengths for DentaQuest:

- DentaQuest met the minimum network requirements for General Dentists in 89.1 percent of all contracted counties. In urban counties, where DentaQuest did not meet the minimum network requirements for General Dentists, access was 99.9 percent. In rural counties, in the single county where DentaQuest did not meet the minimum network requirements for General Dentists, access was 97.7 percent. 
- DentaQuest met the minimum network requirements for Orthodontists in 81.3 percent of all contracted counties. 
- While DentaQuest did not meet the minimum network requirements for Oral Surgeons across all contracted counties, in all urban counties, access to oral surgeons was greater than 99.9 percent. 
- While DentaQuest met the minimum network requirements for Pediatric Dentists in only 48.4 percent of all contracted counties across urbanicity, in urban counties, access to Pediatric

Dentists was consistently greater than 99 percent except for one county for which access was 88.8 percent.

- Through DentaQuest's use of change logs and the internal audit process in its provider data storage, DentaQuest demonstrated the capabilities of effective internal data validation.
- DentaQuest demonstrated the ability to maintain accurate and complete provider information through its quarterly directory validation process.

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 Oral Surgeons in 54.7 percent of all contracted counties. In rural counties, DentaQuest met the minimum network requirements for Oral Surgeons in only nine counties, achieving 99.4 percent access in one additional county. Rural counties otherwise demonstrated rates of access ranging from 0 percent to 30.6 percent. DentaQuest performed similarly in frontier counties, meeting the minimum network requirements for Oral Surgeons in seven counties, and demonstrating rates of access from 0 percent to 86.4 percent in all other contracted frontier counties.
- As described in Strength #4, DentaQuest did not meet the minimum network requirements for Pediatric Dentists in 51.6 percent of all contracted counties. Particularly impacted were rural and frontier counties, where among counties not meeting the standard access ranged from 0 percent to 99.9 percent of all members.
- DentaQuest indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when DentaQuest is informed of a change in member demographic information.

While HSAG acknowledges a shortage of providers in rural and frontier counties, to continue to address these opportunities for improvement, HSAG recommends DentaQuest:

- Conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether 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.
- Explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Follow-Up on FY 2022–2023 NAV Recommendations

FY 2022–2023 NAV Recommendations

HSAG recommended that 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.

HSAG did not identify opportunities for improvement or provide recommendations for DentaQuest during the PDV activity conducted in FY 2022–2023.

FY 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA activity were not evaluated.

Assessment of DentaQuest's Approach to Addressing FY 2022–2023 NAV Recommendations

In response to HSAG's recommendations, DentaQuest reported taking the following actions:

- DentaQuest will continue 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 network.

Based on the above response, DentaQuest worked to address the NAV recommendations from FY 2022–2023, 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 2023–2024 was HSAG's first year conducting a ISCA activity for the Department. As such, prior recommendations for the ISCA 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 2023, DentaQuest received and investigated one potential QOCG case. DentaQuest's average CHP+ membership in CY 2023 was 68,371. The number of members enrolled as of December 31, 2023, was not reported by DentaQuest. The one QOC case investigated by DentaQuest was not substantiated.

DentaQuest: Strengths

Based on QOCG and QOCC audit activities in FY 2023–2024, HSAG found the following strengths for DentaQuest:

- A policy and procedure submitted by DentaQuest described the process for identifying and investigating possible QOCGs. Based on the review of the one case submitted, DentaQuest investigated and tracked QOCG investigations adequately.

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 assigned a severity rating level within the universe submission to the one case; however, information regarding severity levels, definitions, and possible assigned action were not included within the documents submitted.
- The *DentaQuest Member Handbook* and the *Provider Manual* defined "grievance" to include QOC or services; however, these documents did not specify what circumstance(s) may be considered a QOCG.
- DentaQuest's submitted documents did not specifically address initiating a CAP with a provider/facility.
- DentaQuest did not address reporting QOCGs to regulatory agencies.
- During the interview, DentaQuest staff members explained how DentaQuest does not follow up with members to determine if their immediate dental healthcare needs are being met.
- DentaQuest staff members did not describe processes for case-specific reporting to the Department when a potential QOCG case is submitted to DentaQuest by the Department or when submitting a QOC summary.

To address these opportunities, HSAG recommends DentaQuest:

- Review and revise applicable policies and procedures to include severity rating levels, definitions, and possible actions based on the assigned levels.
- Add language in the member materials (e.g., member handbook, quick reference guide, member newsletters) defining both "member grievance" and "QOCG," offering examples of what is considered a QOCG, and providing additional detail regarding how a member can submit a QOCG.
- Consider updating policies and procedures regarding when a CAP is to be initiated to a provider/facility. Consider updating applicable policies and procedures regarding the process for reporting QOCGs to regulatory agencies and under what circumstance(s).
- Update policies and procedures to ensure all members impacted by QOCGs are outreached to ensure immediate healthcare needs are being met.
- Work with the Department regarding the Department's expectation that DentaQuest identify, investigate, track, trend, and close QOCGs.

Follow-Up on FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

In FY 2022–2023, HSAG recommended 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 QOCGs and QOCCs 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.

Review and Assessment of DentaQuest's Approach to Addressing FY 2022–2023 QOC Grievances and Concerns Audit Recommendations

DentaQuest reported addressing HSAG's recommendations by:

- Working on new policies and procedures to align with CMS regulations and State contract language.

DentaQuest still has the opportunity to continue addressing HSAG's recommendations to improve overall QOCG processes and increase compliance. DentaQuest should continue addressing the recommendations made by HSAG and work with the Department regarding expectations and prepare for guidance from the Department for upcoming contractual changes and requirements.

Appendix A. CHP+ Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for MY 2023 for measures with a hybrid option, along with the percentile ranking for each MY 2023 hybrid rate.

Table A-1—MY 2023 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	42.86%	83.93%	≥90th
Combination 7	39.29%	76.79%	≥90th
Combination 10	30.36%	53.57%	≥90th
Immunizations for Adolescents			
Combination 1	66.09%	78.26%	25th–49th
Combination 2	40.00%	49.57%	≥90th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	74.80%	93.19%	≥90th
Counseling for Nutrition—Total	78.17%	84.43%	≥90th
Counseling for Physical Activity—Total	77.31%	82.97%	≥90th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	NA	NA	—

— indicates that the rate was not comparable to benchmarks.

Table A-2 shows RMHP's rates for MY 2023 for measures with a hybrid option, along with the percentile ranking for each MY 2023 hybrid rate.

Table A-2—MY 2023 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	62.50%	65.38%	50th–74th
Combination 7	56.73%	60.58%	75th–89th
Combination 10	35.58%	38.46%	75th–89th
Immunizations for Adolescents			
Combination 1	64.73%	66.67%	<25th
Combination 2	28.42%	29.90%	25th–49th

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	18.02%	86.62%	50th–74th
Counseling for Nutrition—Total	24.57%	77.37%	50th–74th
Counseling for Physical Activity—Total	20.43%	79.08%	75th–89th
Maternal and Perinatal Health			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	52.78%	94.44%	≥90th