CHP+

Child Health Plan *Plus*

2018–2019 External Quality Review Technical Report for Child Health Plan *Plus*

November 2019

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

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1. Executive Summary

Summary of 2018–2019 Statewide Performance by External Quality Review Activity With Trends

Assessment of Compliance With CHIP Managed Care Regulations

Results

In fiscal year (FY) 2018–2019, Health Services Advisory Group, Inc. (HSAG) reviewed four standards as directed by the Colorado Department of Health Care Policy and Financing (the Department) (see Section 2—Reader's Guide, Methodology).

Table 1-1 displays the statewide average 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. [1-1]

Table 1-1—Compliance With Regulations Statewide Trended Performance for CHP+ MCOs

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	84%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	85%	93%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)**	**85%**	**80%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)**	**80%**	**90%**
Standard V—Member Information (2014–2015, 2017–2018)	72%	95%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	65%	84%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	90%	90%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)**	**94%**	**97%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	92%	NA

[1-1] In FY 2018–2019 the Department contracted with one dental prepaid ambulatory health plan (PAHP). Therefore, no statewide performance or trend information related to dental care is available for this section. For complete external quality review (EQR) findings for the State's dental PAHP, see Section 3.

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)**	**88%**	**87%**

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

***Bold text indicates standards that HSAG reviewed during FY 2018–2019.*

Colorado's Child Health Plan *Plus* (CHP+) managed care organizations (MCOs) demonstrated improved performance in the most recent year of review for six of the 10 standards as compared to the previous year the standard was reviewed. For the standards with improved performance, four of the six standards, Standard I—Coverage and Authorization of Services, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard VI—Grievance and Appeal System, improved substantially (10 percentage points or more) compared to the previous year the standard was reviewed. One standard, Standard III—Coordination and Continuity of Care, experienced a 5 percentage point decline in performance. Two standards, Standard VII—Provider Participation and Program Integrity and Standard X—Quality Assessment and Performance Improvement, remained relatively stable. Due to new or revised federal requirements for Standard IX—Subcontracts and Delegation, HSAG scored requirements in this standard as not applicable to CHP+ MCOs in FY 2017–2018; therefore, no statewide comparative results are available for Standard IX.

Compliance results for Colorado's dental PAHP are not included in Table 1-1 due to the compliance review being in a readiness format which includes abbreviated standards. Therefore, results could not be averaged with the other CHP+ MCOs. For individual health plan scores and findings, including findings for the dental PAHP, see Section 3 of this report. For the MCO comparison of scores for 2018–2019 standards, see Section 4, Table 4-1.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

In FY 2018–2019, CHP+ MCOs' statewide performance in six out of nine applicable standards was 90 percent overall compliance or better. In three standards, performance remained below 90 percent compliant. To assist the CHP+ MCOs with revisions to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations released in May 2016 and effective for CHIP health plans July 1, 2018, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions.

Based on the described performance, HSAG recommends that CHP+ health plans continue to incorporate and implement processes to comply with federal managed care regulations released May 2016 (effective for CHP+ health plans as of July 1, 2018), paying particular attention to Standard III—Coordination and Continuity of Care, Standard VI—Grievance and Appeal System, and Standard X—Quality Assessment and Performance Improvement. Since Standard IX—Subcontracts and Delegation

was scored "NA" in its most recent year for review for the CHP+ MCOs, HSAG also recommends that the Department and the health plans ensure that policies, procedures, and processes are in place to implement these new regulations.

Validation of Performance Measures

Information Systems (IS) Standards Review Results

HSAG reviewed the final audit reports (FARs) produced by each MCO's certified HEDIS compliance auditor. Each FAR included the auditor's evaluation of the MCOs' IS capabilities for accurate HEDIS reporting. For the current reporting period, Colorado Access (COA), Denver Health Medical Plan, Inc. (DHMP), Friday Health Plans of Colorado (FHP), Kaiser Permanente Colorado (Kaiser), and Rocky Mountain Health Plans (RMHP) were fully compliant with all IS standards relevant to the scope of the performance measure validation (PMV) performed by the MCOs' licensed HEDIS auditors. During review of the IS standards, the HEDIS auditor did not identify any notable issues that had a negative impact on HEDIS reporting. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology, and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

Table 1-2 and Table 1-3 display the Colorado CHP+ weighted averages for HEDIS 2017 through HEDIS 2019, along with the percentile ranking for each high- and low-performing HEDIS 2019 measure rate. Statewide performance measure results for HEDIS 2019 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018 (referred to throughout this report as percentiles), when available. Rates for HEDIS 2019 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2019 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-2]

Additional Colorado CHP+ weighted average measure rates can be found in Section 4. Of note, Delta Dental (i.e., the CHP+ dental PAHP) was only required to report one measure, *Annual Dental Visit*. These results can be found in Section 3.

[1-2] Performance comparisons are based on the Chi-square test of significance. A change in performance is considered statistically significant in this report if the *p*-value from the Chi-square test was less than 0.05 and the rate difference was at least 3 percentage points.

Table 1-2—Colorado CHP+ Weighted Averages—HEDIS 2019 High Performers

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 6	41.61%	40.51%	45.31%^	50th–74th
Combination 8	40.34%	39.53%	44.29%^	50th–74th
Combination 9	38.50%	36.49%	42.27%^	75th–89th
Combination 10	37.59%	35.77%	41.39%^	75th–89th
Immunizations for Adolescents				
Combination 2 (Meningococcal; Tetanus, Diphtheria Toxoids, and Acellular Pertussis [Tdap]; Human Papillomavirus [HPV])	—	33.79%	39.02%^	75th–89th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.07%	0.04%	≥90th
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	91.24%	93.84%	94.09%	75th–89th
Asthma Medication Ratio[1]				
Ages 5 to 11 Years	85.80%	82.90%	82.63%	≥90th
Ages 12 to 18 Years	73.72%	74.03%	71.32%	75th–89th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
— Indicates that NCQA recommended a break in trending for HEDIS 2018; therefore, HEDIS 2017 rates are not displayed for this measure.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

The HEDIS 2019 statewide weighted average for measures within the Pediatric Care domain demonstrate strength with vaccinations for children and adolescents, with all five vaccination rates displayed in Table 1-2 demonstrating significant improvement from the prior year. Of note, COA exceeded the 75th percentile for all five rates and Kaiser exceeded the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* rate. Conversely, performance for RMHP and FHP demonstrated opportunities for improvement with RMHP's *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* rate below the 10th percentile and all five of FHP's vaccination rates below the 10th percentile.

The statewide weighted average and rates for all five MCOs exceeded the 90th percentile for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure, indicating strength in the Preventive Screening domain by not screening young women for cervical cancer unnecessarily.

For the Respiratory Conditions domain, all five MCOs performed above the 50th percentile for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, with both DHMP and Kaiser exceeding the 90th percentile. The statewide weighted average rates for the *Asthma Medication Ratio* measure are mainly representative of COA's performance, as the other MCOs' rates were too small to report (i.e., denominator less than 30).

Table 1-3—Colorado CHP+ Weighted Averages—HEDIS 2019 Low Performers

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	65.30%	62.54%	66.78%^	10th–24th
Combination 3	63.61%	61.05%	65.16%^	10th–24th
Combination 4	61.14%	59.17%	63.13%^	10th–24th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	3.04%	2.63%	5.06%	<10th
Six or More Visits	48.01%	51.41%	48.28%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile Documentation—Total[1]	16.67%	19.89%	22.71%	<10th
Counseling for Nutrition—Total	18.14%	20.12%	21.46%	<10th
Counseling for Physical Activity—Total	14.31%	15.87%	17.58%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	90.02%	90.65%	92.33%	10th–24th
Ages 25 Months to 6 Years	82.88%	80.91%	82.93%	10th–24th
Ages 7 to 11 Years	88.99%	87.49%	87.66%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	35.31%	33.66%	36.52%	<10th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication[2]				
Initiation Phase	13.02%	21.84%	15.21%	<10th
Continuation and Maintenance Phase	20.00%	21.57%	20.00%	<10th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[1]				
Total	3.37%	5.62%	4.04%	10th–24th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

Despite demonstrating significant improvement for three *Childhood Immunization Status* indicators for HEDIS 2019, opportunities exist for improvement as the statewide weighted average remained below the 25th percentile. Of note, the *Childhood Immunization Status* combination rates demonstrated significant improvement for COA, whereas performance for all other MCOs declined from the prior year. Further, the statewide weighted averages for the *Well-Child Visits in the First 15 Months of Life* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures fell below the 10th percentile, indicating improvement efforts should be focused on identifying the factors contributing to the rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.[1-3]

Within the Access to Care domain, the statewide weighted average fell below the 25th percentile for three of the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators. Only one indicator rate for the MCOs (Kaiser's *Ages 12 to 24 Months*) performed above the 50th percentile, suggesting the MCOs and the Department should conduct root cause analyses for the low access to care rates to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care or the need for community outreach and education). Once the causes are identified, the MCOs and the Department should work with providers to establish potential performance improvement strategies and solutions to increase the access to care rates.

None of the reportable *Chlamydia Screening in Women—Ages 16 to 20 Years* rates within the Preventive Screening domain were above the 50th percentile for HEDIS 2019, indicating opportunities exist to increase screenings for chlamydia for young women.

The measures determined to be low performers for HEDIS 2019 within the Mental/Behavioral Health domain are mainly representative of the performance of COA, Kaiser, and RMHP, as most rates for the remaining MCOs were not reportable (i.e., denominator less than 30). The MCOs and the Department should focus on ensuring appropriate prescribing and monitoring for child members on medications for behavioral health (BH) conditions.

[1-3] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: July 2, 2019.

Statewide Opportunities for Improvement and Recommendations Related to Performance Measure Rates and Validation

The MCOs' HEDIS compliance FARs indicated that all of the MCOs followed NCQA methodology, and that the rates submitted were valid, reliable, and accurate. Therefore, HSAG identified no opportunities for improvement or recommendations related to IS standards review.

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2*, *3*, and *4*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, and *Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Statewide performance for HEDIS 2019 demonstrated opportunities to improve the access to preventive care and services for members, including chlamydia screening and follow-up care for members prescribed ADHD medications.

Validation of Performance Improvement Projects

Results

Table 1-4 summarizes performance improvement project (PIP) performance for each CHP+ health plan in FY 2018–2019. Each CHP+ health plan conducted a PIP focusing on a topic related to access to care.

Table 1-4—Statewide PIP Results for CHP+ Health Plans

Health Plan	PIP Topic	Module Status	Validation Status
COA	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
DHMP	*Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age*	*Completed Module 1 and Module 2*	NA*
FHP	*Well-Child Visits in the 6th Through 14th Years of Life*	*Completed Module 1 and Module 2*	NA*
Kaiser	*Improving CHP+ Adolescent Well-Visit Adherence*	*Completed Module 1 and Module 2*	NA*
RMHP	*Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	*Completed Module 1 and Module 2*	NA*
Delta Dental	*Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year*	*Completed Module 1 and Module 2*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.*

Table 1-4 summarizes PIP performance among the CHP+ health plans in FY 2018–2019. During this validation cycle, the CHP+ health plans initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs run on an 18-month schedule and will continue into the next FY. During FY 2018–2019, the primary PIP activities included the CHP+ health plans receiving training and technical assistance on the rapid-cycle PIP process and developing the foundation of the projects in the first two modules of the process. Table 1-4 summarizes how far through the five modules of the rapid-cycle PIP process each CHP+ health plan progressed. As noted in the "Validation Status" column in the table, no PIPs progressed to being evaluated on outcomes or receiving a final validation status.

During FY 2018–2019, the CHP+ health plans passed Module 1 and Module 2, achieving all validation criteria for the first two modules for all five PIPs. The FY 2018–2019 validation findings for the five PIPs suggested that all CHP+ health plans designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. In the next FY, four of the CHP+ health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. One health plan, Delta Dental, will not progress beyond Module 1 and Module 2 because Delta Dental's contract with the State

of Colorado for provision of dental services for the Department's CHP+ managed care program ended at the end of the FY.

Statewide Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Going forward, HSAG recommends that the CHP+ health plans use appropriate tools, such as process maps and failure modes and effects analyses (FMEAs), to identify gaps and failures in the processes related to PIP outcomes. The CHP+ health plans should develop and test innovative interventions to address identified process failures through carefully designed Plan-Do-Study-Act (PDSA) cycles. Access to relevant data for tracking intervention effectiveness and overall progress toward achieving the goal for improvement will be critical to the success of the projects.

As the Department explores potential topics for the next round of rapid-cycle PIPs, HSAG recommends that data access and availability related to the potential topics be considered. For the CHP+ health plans to leverage the strengths of the rapid-cycle improvement process, ready access to both historical and prospective data is critical. Data are used to determine health plan-level baseline performance, to set a goal for improvement in relation to baseline performance, and to monitor progress toward achieving the goal for improvement. If relevant health plan-level data are not readily available, the CHP+ health plans will spend time, energy, and resources on developing data collection processes and tools that could otherwise be directed toward interventions that can directly lead to improvement.

CAHPS Survey

Results

Table 1-5 shows the statewide average results for each CAHPS measure for FY 2016–2017 through FY 2018–2019. The statewide averages presented in Table 1-5 are derived from the combined results of the five CHP+ MCOs.[1-4]

Table 1-5—Question Summary Rates and Global Proportions for Statewide Average

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	85.7%	85.5%	87.1%
Getting Care Quickly	90.2%	91.2%	90.5%
How Well Doctors Communicate	95.9%	95.8%	95.4%
Customer Service	85.7%	84.1%	84.0%
Shared Decision Making	81.1%	78.5%	80.4%

[1-4] No CAHPS survey was conducted for Colorado's dental PAHP, Delta Dental.

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Rating of Personal Doctor	74.4%	75.7%	76.6%
Rating of Specialist Seen Most Often	70.9%	78.7%	77.9%
Rating of All Health Care	66.5%	68.1%	67.1%
Rating of Health Plan	61.0%	61.4%	67.1%

Over the three-year period, the following two measures showed an upward rate trend: *Rating of Personal Doctor* and *Rating of Health Plan*. Conversely, the *How Well Doctors Communicate* and *Customer Service* measures showed a slight downward rate trend. The rates for the remaining measures fluctuated, either increasing or decreasing slightly over the periods.

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

The CAHPS survey is designed primarily to measure perceived quality of care, with one measure also relating to timeliness of care (*Getting Care Quickly*) and another also relating to access to care (*Getting Needed Care*). Based on CAHPS results statewide, there were two measure rates for which four CHP+ MCOs experienced at least a slight decrease in performance from FY 2017–2018 to FY 2018–2019—*How Well Doctors Communicate* and *Rating of All Health Care*. The statewide average rate also demonstrated a slight decrease in performance for these rates. These rates may be a measure of the quality domain. Performance in the *How Well Doctors Communicate* and *Rating of All Health Care* measures may be related to a variety of factors including members' perceived ability to access care, providers' cultural competency or communication abilities regarding specific treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by office staff members and/or providers. HSAG offers the following recommendations for the Department to consider:

- Collaborate with the MCOs to assess provider staff members' and providers' communication skills and develop training programs designed to address issues found related to both staff members and providers.
- Consider encouraging coordination between MCOs to ensure diversity and frequency of trainings on communication and cultural competency using web-based or online trainings.
- Continue to reward creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, offering member mentorship programs, coordinating with community organizations that support disease management programs, and offering health education and support related to chronic conditions.

Validation of Network Adequacy

Results

HSAG used a desk review approach to collect and review provider data from the CHP+ health plans (five MCOs, one dental PAHP, and one administrative service organization [ASO]—the State Managed Care Network [SMCN]); develop the provider crosswalks; and conduct a provider composition analysis (PCA) among all ordering, referring, and servicing providers contracted to provide care through the CHP+ health plans.

Prior to requesting the plans' provider network data, HSAG distributed a Data Structure Questionnaire to the plans, and the plans' responses reflected a variety of methods for collecting and maintaining provider data. Each plan reported conducting formal data validation to ensure that its data systems contain current contracting status, demographics, practice location(s), practice accommodation(s), and panel capacity for each contracted provider. Questionnaire findings also highlighted plans' inconsistent data collection for provider classification attributes (e.g., provider type, specialty, taxonomy code, and degree/credential), affecting the development of standard provider categories. Though plans reported that they verify providers' self-reported classification information, they did not supply documentation on the verification processes or specifications used to determine a provider's classification. Additionally, plans' questionnaire responses indicated that no standardized list of attribute options was offered to providers for use with the Colorado Health Care Professional (CHCP) application, resulting in a variety of similar provider type and specialty data values that may need to be incorporated into the plans' data cleaning efforts.

All plans submitted provider network data for the study, though the plans' data values did not consistently align with information on available provider attribute values reported in the Data Structure Questionnaires. Many plans' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., nurse practitioners [NPs] or physician assistants [PAs]). While these plans collect detailed subspecialty information for physicians, similar information was not reported for the non-physician providers. For example, an NP may have been listed in the plan's data with a provider type of "Nurse Practitioner" and a provider specialty of "Nurse Practitioner." Without using taxonomy codes, HSAG was not able to assign these NPs to categories for primary care providers (PCPs) or women's health providers.

PCA results illustrated the need for standardized provider category definitions to ensure consistent network analysis results across plans. The PCA results also reinforced the need for the plans to evaluate the level of specificity available in their provider data systems. For example, plans may count any NP or clinical nurse specialist as a PCP, without regard to nursing subspecialties. Additionally, interChange provider data include hospitals, federally qualified health centers (FQHCs), rural health centers (RHCs), and community mental health centers (CMHCs); however, plans may not have had these providers counted in the PCA due to the way in which these providers were reflected in the plans' data.

Statewide Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

As the Department's first comprehensive investigation into the CHP+ health plans' provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing the plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the plans. The Department should also develop standardized quarterly network adequacy reporting templates for each plan type (e.g., CHP+ MCOs versus the ASO or the CHP+ dental PAHP). To ensure consistent reporting within each plan type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps
    - Content should allow the plan to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206[1-5] and reporting requirements under 42 CFR §438.207[1-6]
  - Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the plan
  - Methodology information for any expected calculations (e.g., time/distance calculations should be based on driving distances between each member and the nearest applicable provider)
  - Templates for any expected data tables, including definitions for each cell that the plan is expected to populate
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the plans and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the plans' data values for provider type, specialty, and credentials. The plans should assess available data values in their provider data systems and standardize available data value options.

[1-5] Availability of Services, 42 CFR §438.206. Available at https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8. Accessed on May 20, 2019.

[1-6] Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207. Accessed on May 20, 2019.

Statewide Conclusions and Recommendations

Based on the results of the five external quality review (EQR) activities performed during FY 2018–2019, HSAG made the following observations about how these activities provided assessment related to the quality, timeliness of, and access to care and services. Opportunities for improvement were primarily related to the quality and access domains of care. Related to the Compliance with Regulations EQR activity, the low-scoring standards were standards that may potentially impact the quality domain. Also related to the quality domain, recommendations resulting from the PIP activity and the validation of network adequacy were related to data quality for the CHP+ health plans as well as the Department. The two CAHPS measures in which four CHP+ MCOs experienced decreased performance were measures that were related the quality of care domain. HEDIS measures demonstrated low performing scores in measures that were related to preventive care and immunizations, potentially related to the access and quality domains.

Quality Strategy

The Health First Colorado 2019 Quality Strategy (Quality Strategy) addresses the key elements recommended in the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, as well as in the guidance published on the Medicaid.gov website and in the State Medicaid Director letter guidance on designing and implementing State Quality Strategies. As recommended by CMS, the Department's Quality Strategy provides a blueprint for advancing the State's commitment to improving quality healthcare delivered through the Regional Accountable Entities (RAEs) and their contracted MCOs. Colorado's primary system of healthcare delivery and payment is designed to reward value and quality of care received by Health First Colorado and CHP+ members. The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve quality of care based on the following Department Strategic Quality Improvement Goals:

- Decreasing healthcare costs and increasing affordability for individuals, families, employers, and the government
- Enhancing delivery system innovation to include:
  - Increasing and monitoring members' access to care and provider network adequacy
  - Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care
  - Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles
  - Implementing pay-for-performance to providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients

- Improving patient safety to include:
  - Ensuring members are connected to the right care, at the right time, every time
  - Promoting effective prevention and treatment of chronic disease
- Improving health outcomes, member experience, and patient safety through clinical analytics, evidence-based practices, and adoption

The Department's Quality Strategy includes a variety of performance measures designed for driving performance-based outcomes. Overall quantifiable objectives are related to closing performance gaps by 10 percent while identifying specific processes and policies that can become more person-centered.

In addition, Colorado's Quality Strategy addresses transparency, care coordination, and social determinants of health where possible based on community feedback as recommended by CMS. Health plan and State quality reporting is available at https://www.colorado.gov/hcpf. The Quality Strategy describes the interagency and community-based committees and collaborative teams that provide input and feedback in the ongoing design and revision of the Medicaid and CHP+ healthcare delivery system.

The Department further leverages its relationship with its external quality review organization (EQRO), HSAG, to conduct all mandatory and several optional EQR-related activities. Over the 18-year relationship, HSAG and the Department have collaborated to design State-specific technical assistance and optional activities and projects developed to provide information needed to shape the iterative design of the Medicaid and CHP+ programs.

HSAG recommends that the Department further collaborate with CMS to identify when CMS will update the Quality Strategy Toolkit for States based on the revised Medicaid regulations released in May 2016 and the revised Code of Colorado Regulations at 10 CCR 2505-10, Section 8.209.[1-7] Although the Department is in compliance with identified regulations within the CMS Quality Strategy Toolkit for States, HSAG recommends that the Department revise the Quality Strategy for its next submission, via restatement of the current regulations or via a crosswalk to the CMS Quality Strategy Toolkit for States.

[1-7] Department of Health Care Policy and Financing. Code of Colorado Regulations. Available at: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8299&fileName=10 CCR 2505-10 8.200. Accessed on: May 20, 2019.

2. Reader's Guide

Report Purpose and Overview

States with CHIP healthcare delivery systems that include MCOs and PAHPs (collectively referred to as health plans) are required to annually provide an assessment of the State's health plans' performance related to the quality of, timeliness of, and access to care and services provided by each health plan (42 CFR §438.364). The Department administers and oversees the CHP+ program (Colorado's implementation of the Children's Health Insurance Program). To meet this requirement, the Department contracted with HSAG to perform the assessment and to produce this EQR annual technical report based on EQR-related activities that HSAG conducted with the CHP+ health plans throughout FY 2018–2019. The CHP+ health plans located in Colorado are listed in Table 2-1.

Table 2-1—Colorado CHP+ Health Plans

CHP+ Health Plans	Services Provided
Colorado Access (COA)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Denver Health Medical Plan, Inc. (DHMP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Friday Health Plans of Colorado (FHP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Kaiser Permanente Colorado (Kaiser)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Rocky Mountain Health Plans (RMHP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Delta Dental of Colorado (Delta Dental)	Dental services.

How This Report Is Organized

Section 1—Executive Summary includes a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQRO activities in FY 2018–2019. This section also includes a summary description of relevant trends over a three-year period for each EQRO activity as applicable, with references to the section where the health plan specific results can be found where appropriate. In addition, Section 1 includes any conclusions drawn and recommendations made for statewide performance improvement, if applicable.

Section 2—Reader's Guide provides a brief overview of Colorado's CHP+ healthcare delivery system and its managed care organizations and describes the purpose and overview of this EQR annual technical report, the authority under which it must be provided, and the EQR activities conducted during

FY 2018–2019. Section 1 also provides an overview of the methodology for each EQR activity performed and how HSAG used results and data obtained to draw conclusions.

Section 3—Evaluation of Colorado's CHP+ Health Plans provides summary level results for each EQR activity performed for the CHP+ health plans. This information is presented by health plan and provides an activity-specific assessment of the quality of, timeliness of, and access to care and services for each health plan as applicable to the results obtained and activities performed.

Section 4—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 also identifies, through presentation of results for each EQR activity, statewide trends and commonalities used to derive statewide conclusions and recommendations.

Section 5—Assessment of CHP+ Health Plan Follow-Up on Prior Recommendations provides, by EQR activity, a health plan-specific assessment of the extent to which the health plans were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activities.

Scope of EQR Activities

The CHP+ health plans were subject to three federally mandated EQR activities and two optional activities. As set forth in 42 CFR §438.358, the mandatory activities were:

- **Assessment of compliance with CHIP managed care regulations (compliance with regulations).** Assessment of compliance with regulations was designed to determine the health plans' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of four standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To assess the accuracy of the performance measures reported by or on behalf of the health plans, each health plan's licensed HEDIS auditor validated each of the performance measures selected by the Department for review. The validation also determined the extent to which performance measures calculated by the health plans followed specifications required by the Department.
- **Validation of performance improvement projects.** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.

The optional activities conducted for the CHP+ health plans were:

- **CAHPS survey.** HSAG conducted surveys and reported results for all CHP+ MCOs on behalf of the Department. No CAHPS survey was conducted for Colorado's dental PAHP, Delta Dental.

- **Validation of network adequacy.** HSAG reviewed Colorado's existing network adequacy standards and obtained network information from the managed care entities and the Department to analyze and assess the Department's network needs and establish standardized provider category definitions across the CHP+ health plans.

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 of, timeliness of, and access to care and services.

Quality

The Centers for Medicare & Medicaid Services (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, 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."[2-1]

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."[2-2] 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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2-3]

Methodology

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

Assessment of Compliance With CHIP Managed Care Regulations

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance based on federal healthcare regulations. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a strategy and monitoring tools to review compliance with these standards and managed care contract requirements related to each standard. HSAG also reviewed the health plans' administrative records to evaluate compliance related to member appeals and grievances.

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 site 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 of, timeliness of, and access to 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.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Technical Methods of Data Collection

To assess for health plans' compliance with regulations, HSAG conducted the five activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[2-4] Table 2-2 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

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

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and managed care 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 monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Prior to the scheduled date of the on-site 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 an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site record reviews. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested. • Documents submitted for the desk review and the on-site 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. Each health plan also submitted a list of all CHP+ (1) individual providers credentialed between July 1, 2018, and December 31, 2018; (2) individual providers recredentialed between July 1, 2018, and December 31, 2018; and (3) all organizations with which the health plan had an agreement between July 1, 2018,

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sept 19, 2018.

For this step,	HSAG completed the following activities:
	and December 31, 2018. HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site 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 on-site portion of the review.
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plans' key staff members to obtain a complete picture of the health plans' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plans' performance. • HSAG reviewed a sample of administrative records related to credentialing and recredentialing to evaluate implementation of federal managed care regulations and State contract requirements. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original-source documents that were confidential or proprietary or were requested as a result of the pre-on-site document review or on-site interview.) • At the close of the on-site portion of the site review, HSAG met with the health plan's staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the site review report template to compile the findings and incorporate information from the pre-on-site and on-site 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 site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. • HSAG distributed the final report to the health plan 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 manual and directory
- 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 (processing of grievances and appeals)
- Interviews with key health plan staff members conducted on-site

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains. Each standard may involve assessment of more than one domain 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 of, timeliness of, or access to care and services provided by the MCOs. Table 2-3 depicts assignment of the standards to the domains.

Table 2-3—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓		✓
Standard IV—Member Rights and Protections	✓		
Standard VIII—Credentialing and Recredentialing	✓	✓	
Standard X—Quality Assessment and Performance Improvement	✓		

Validation of Performance Measures

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) 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

The Department required that each health plan undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA-licensed organization. CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012,[2-5] identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the FAR for each health plan and aggregated several sources of HEDIS-related data to confirm that the health plans met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.*[2-6]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan'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.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/externalquality-review/index.html. Accessed on: Oct 10, 2018.

[2-6] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS 2018 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The health plans were responsible for obtaining and submitting their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the health plan'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 health plans, it did review the audit reports produced by the other licensed audit organizations. Through review of each health plan's FAR, HSAG determined that all licensed organizations followed NCQA's methodology in conducting their HEDIS Compliance Audits.

Description of Data Obtained

As identified in the HEDIS audit methodology, key data sources were obtained and reviewed to ensure that data were validated in accordance with CMS' requirements and to confirm that only valid results were included in this report. Table 2-4 outlines HEDIS audit activities and steps reviewed by HSAG, along with the corresponding data sources.

Table 2-4—Description of Data Sources Reviewed

Data Reviewed	Source of Data
Pre-On-Site Visit/Meeting—This was the initial conference call or meeting between the HEDIS compliance auditor and the health plan staff. HSAG verified that key HEDIS topics such as timeliness and on-site review dates were addressed by the licensed organizations.	HEDIS 2019 FAR
Roadmap Review—This review provided the health plan's HEDIS compliance auditors with background information on policies, processes, and data in preparation for on-site validation activities. The health plans were required to complete the Roadmap to provide their lead auditor audit team with the necessary information to begin validation activities. HSAG looked for evidence in the final report that the licensed HEDIS auditor completed a thorough review of all components of the Roadmap.	HEDIS 2019 FAR

Data Reviewed	Source of Data
Certified Measure Review—If any health plan used a vendor whose measures were certified by NCQA to calculate that health plan's measure rates, HSAG verified that the certification was available and that all required measures developed by the vendor were certified by NCQA.	HEDIS 2019 FAR and Measure Certification Reports
Source Code Review—HSAG ensured that the licensed HEDIS auditor reviewed the programming language for calculating any HEDIS measures that did not undergo NCQA's measure certification process. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (to determine if rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).	HEDIS 2019 FAR
Survey Vendor—If the health plan used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-certified survey vendor was used. A certified survey vendor must be used if the health plan performed a CAHPS survey as part of HEDIS reporting.	HEDIS 2019 FAR
CAHPS Sample Frame Validation—HSAG validated that the licensed organizations performed detailed evaluations of the source code used to access and manipulate data for CAHPS sample frames. This validation reviewed the source code to ensure that data were correctly queried in the output files, and HSAG conducted a detailed review of the survey eligibility file elements, including the healthcare organization's name, product line, product, unique member ID, and subscriber ID, as well as the member name, gender, telephone number, date of birth, mailing address, continuous enrollment history, and prescreen status code (if applicable).	HEDIS 2019 FAR
Supplemental Data Validation—If the health plan used any supplemental data for reporting, the HEDIS compliance auditor must validate the supplemental data according to NCQA guidelines. HSAG verified that the NCQA-required processes were followed to validate the supplemental databases.	HEDIS 2019 FAR
Convenience Sample Validation—Per NCQA guidelines, the HEDIS auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the medical record review (MRR) process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, if the current MRR process has not changed significantly from the previous year, and if the health plan did not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the HEDIS auditors determined whether or not the health plans were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by the HEDIS auditor the specific reasons were documented.	HEDIS 2019 FAR

Data Reviewed	Source of Data
Medical Record Review—The HEDIS auditors are required to perform a more extensive validation of medical records reviewed, which is conducted late in the abstraction process. This validation ensures that the review process was executed as planned and that the results are accurate. HSAG reviewed whether or not the auditor performed a re-review of a minimum random sample of 16 medical records for each measure group and the exclusions group to ensure the reliability and validity of the data collected.	HEDIS 2019 FAR
Interactive Data Submission System (IDSS) Review—The health plans are required to complete NCQA's IDSS for the submission of audited rates to NCQA. The auditor finalizes the IDSS by completing the audit review and entering an audit result. This process verifies that the auditor validated all activities that culminated in a rate by the health plans. The auditor locks the IDSS so that no information can be changed. HSAG verified that the auditors completed the IDSS review process. In a situation where the health plans did not submit the rates via IDSS, HSAG validated the accuracy of the rates submitted by the health plans in a data submission template created by HSAG.	HEDIS 2019 IDSS

Table 2-5 identifies the key validation elements reviewed by HSAG. HSAG identified whether or not each health plan was compliant with the key elements as described by the licensed HEDIS auditor organization in the FAR and the IDSS. As presented in Table 2-5, a check mark symbol indicates that the licensed organization conducted the corresponding audit activity according to the HEDIS methodology. Some activities were conducted by other companies, such as NCQA-certified software or survey vendors, which contracted with the health plans. In these instances, the name of the company which performed the required task is listed.

Table 2-5—Validation Activities

	COA	DHMP	FHP	Kaiser	RMHP
Licensed HEDIS Auditor Organization	HealthcareData Company, LLC	Attest Health Care Advisors	DTS Group	DTS Group	DTS Group
Pre-On-Site Visit Call/Meeting	✓	✓	✓	✓	✓
Roadmap Review	✓	✓	✓	✓	✓
Software Vendor	Centauri Health Solutions	Cotiviti	Change Healthcare	None used	Inovalon, Inc.
Source Code/Certified Measure Review	✓	✓	✓	✓	✓
Supplemental Data Validation	✓	✓	Supplemental data were not used	✓	✓
Medical Record Review	Medical record review data were not used	✓	✓	✓	✓
IDSS Review	✓	✓	✓	✓	✓

The preceding table indicates that audits conducted for the health plans included all required validation activities. The health plans used NCQA-licensed organizations to perform the HEDIS audits.

HSAG summarized the results from Table 2-5 and determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology. Therefore, all health plan rates and audit results were determined to be valid, reliable, and accurate.

How Conclusions Were Drawn

IS Standards Review

Health plans must be able to demonstrate compliance with IS standards. Health plans' 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 health plan compliance with the HEDIS Compliance Audit Standards. The IS standards are listed as follows:

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

In the measure results tables presented in Section 3, HEDIS 2017, 2018, and 2019 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA-licensed audit organization according to NCQA standards. With regard to the final measure rates for HEDIS 2017, 2018, and 2019, a measure result of *Small Denominator* (*NA*) indicates that the health plan 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 health plan chose not to report the measure.

Performance Measure Results

The MCOs' HEDIS 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 benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate statistically significant improvement in performance from HEDIS 2018 to HEDIS 2019. Rates shaded red with two carets (^^) indicate statistically significant declines in performance from HEDIS 2018 to HEDIS 2019. Throughout the performance measure results sections in this report, references to "significant" changes in performance are noted; these instances refer to statistically

significant differences between performance from HEDIS 2018 to HEDIS 2019. Performance comparisons are based on the Chi-square test of proportions with results deemed significant with a *p*-value <0.05. However, caution should be exercised when interpreting results of the significance testing, given that significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered 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 IDSS 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. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the 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, where available, for HEDIS 2019 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018 since these indicators are not published in Quality Compass.

For the measures in the Use of Services domain (i.e., *Ambulatory Care*, *Inpatient Utilization—General Hospital/Acute Care*, and *Antibiotic Utilization*), HSAG did not perform significance testing because variances were not provided in the IDSS files; therefore, differences in rates are reported without significance testing. In addition, higher or lower rates do not necessarily indicate better or worse performance for the measures in the Use of Services domain.

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 MCOs to report this rate for the respective HEDIS submission or NCQA recommended a break in trending in HEDIS 2018 or HEDIS 2019. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2019 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 performers 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 significant decline in performance from HEDIS 2018.
  - Ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle compared to national percentiles but declining over time. These measures are those:
  - Below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018.

According to the Department's guidance, all measure rates presented in this report for the MCOs are based on administrative data only. The Department required that all HEDIS 2017, HEDIS 2018, and 2019 measures be reported using the administrative methodology only. However, FHP 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 HEDIS measure results, the following items should be considered:

- MCOs 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 HEDIS 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 medical record review data, as results likely underestimate actual performance. Table 2-6 presents the measures provided in the report that could be reported using the hybrid methodology.

Table 2-6—HEDIS Measures That Can Be Reported Using the Hybrid Methodology

Hybrid Measures
Childhood Immunization Status
Immunizations for Adolescents
Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Adolescent Well-Care Visits
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Prenatal and Postpartum Care

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

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ MCOs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains. This assignment to domains is depicted in Table 2-7.

Table 2-7—Assignment of Activities to Performance Domains

Performance Measures	Quality	Timeliness	Access
Pediatric Care Measures			
Childhood Immunization Status	✓		
Immunizations for Adolescents	✓		
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Access to Care Measures			
*Prenatal and Postpartum Care**	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
*Annual Dental Visit***			✓
Preventive Screening Measures			
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Mental/Behavioral Health Measures			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
Respiratory Conditions Measures			
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Medication Management for People With Asthma	✓		
Asthma Medication Ratio	✓		

Performance Measures	Quality	Timeliness	Access
Use of Services Measures			
Ambulatory Care (Per 1,000 Member Months)	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Antibiotic Utilization	NA	NA	NA

** CHP+ SMCN was required to report just one measure, Prenatal and Postpartum Care.*

*** Delta Dental was required to report just one measure, Annual Dental Visit.*

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

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.

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 Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-7]

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 23, 2019.

Over time, HSAG identified that while the health plans had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few health plans had achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-8] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement.

PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that given the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed.

HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the health plans to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act**: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the health plan summarizes key findings and outcomes and presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

[1-8] Langley GL, Moen R, Nolan KM, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Mar 26, 2019.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission form. In FY 2018–2019, these forms provided detailed information about the PIPs and the activities completed in Module 1 and Module 2.

Following HSAG's rapid-cycle PIP process, the health plans submit each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

How Conclusions Were Drawn

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the health plan accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the health plan accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, the Department required all health plans to choose a specific PIP topic related to the global topic of access to care; therefore, all PIP topics were also assigned to the access domain. This assignment to domains is shown in Table 2-8.

Table 2-8—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

Health Plan	Performance Improvement Projects	Quality	Timeliness	Access
COA	*Well-Child Visits for Members 10–14 Years of Age*	✓		✓
DHMP	*Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age*	✓		✓
FHP	*Well-Child Visits in the 6th Through 14th Years of Life*	✓		✓
Kaiser	*Improving CHP+ Adolescent Well-Visit Adherence*	✓		✓
RMHP	*Improving CHP+ Adolescent Well-Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	✓		✓
Delta Dental	*Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year*	✓		✓

CAHPS Surveys

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information about members' healthcare experiences.

Technical Methods of Data Collection

HSAG administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the CHP+ population. The survey includes a set of standardized items (48 items for the *CAHPS 5.0 Child Medicaid Health Plan Survey* without the Children with Chronic Conditions [CCC] measurement set) that assess members' perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. 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. HSAG aggregated data from survey respondents into a database for analysis.

The survey questions were categorized into nine measures of experience that included four global ratings and five composite measures. The global ratings reflected members' overall experience with their personal doctors, specialists, all healthcare, and health plans. 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*). For any case where a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the CAHPS survey fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures.

Description of Data Obtained

HSAG administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the CHP+ population and stratified the results by the five CHP+ health plans. HSAG followed NCQA methodology when calculating the results.

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for CAHPS to one or more of these three domains. This assignment to the domains is depicted in Table 2-9.

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

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

Validation of Network Adequacy

Objectives

Medicaid and CHIP managed care regulations that were released in May 2016 stated that validation of network adequacy shall commence no later than one year from the issuance of the associated EQR protocol (42 CFR §438.358(b)(1)(iv)). In preparation of the release of the validation of network adequacy protocol, the Department collaborated with HSAG to support a review of current network adequacy documentation and processes; prepare a provider crosswalk for use in future network adequacy validation tasks; and conduct a baseline PCA of the provider networks for all CHP+ health plans.

The provider crosswalk was designed to use provider types, specialties, credentials, and/or taxonomy codes from the Department's and the plans' existing provider data to establish standard definitions for identifying categories of managed care providers (e.g., physician and non-physician PCPs). The primary focus of the PCA was to assess the distribution of providers affiliated with each health plan for the Department's selected provider categories.

Technical Methods of Data Collection

HSAG used a desk review approach to collect documentation and provider data from the Department and participating CHP+ health plans (including the dental PAHP). The Department supplied HSAG with provider network documentation and standards, including the plans' network adequacy contract requirements and quarterly network adequacy reports. In addition, the Department supplied data for all ordering, referring, servicing, and billing providers active with the Department (i.e., registered in interChange). Concurrent with the Department's data extract, each plan completed a brief Data Structure Questionnaire with targeted information regarding its provider data structure(s) and methods for classifying providers. Finally, each CHP+ health plan submitted provider network data using a standardized data requirements document approved by the Department.

Description of Data Obtained

Qualitative data for the study included the Department's provider network documentation and the plans' self-reported Data Structure Questionnaire responses.

Quantitative data for the study included provider-level network data from the Department and each CHP+ health plan, including 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. However, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the plans and a lack of consistent use of taxonomy codes by the Department.

Of note, the Department has not directed the plans to use standard categorization criteria when producing quarterly network adequacy reports, and the Department is unable to identify the CHP+

health plan and/or fee-for-service (FFS) affiliation(s) for each provider, resulting in a reliance on the plans' provider data for this study.

How Conclusions Were Drawn

Following development of the study methodology, the Department approved the following high-level provider categories applicable to CHP+ health plans and aligned with the minimum provider categories identified in Section 42 438.68 of the federal network adequacy standard requirement:

- Facility-Level Providers
  - Hospitals, pharmacies, imaging services, and laboratories
- Prenatal Care and Women's Health Services
  - Individual providers, FQHCs, RHCs, CMHCs, and birthing centers
- PCPs
  - Individual general and pediatric providers, FQHCs and RHCs, CMHCs and school-based health clinics (SBHCs)
- Physical Health Specialists
  - Individual general and pediatric providers, FQHCs and RHCs
- Ancillary Physical Health Services
  - Audiology, optometry, podiatry, and occupational/physical/speech therapy
- Behavioral Health Specialists
  - Individual physician and non-physician providers, FQHCs, RHCs, and CMHCs
  - Mental hospitals and psychiatric residential treatment facilities
  - Substance abuse facilities and licensed addiction counselors
- Primary and Specialty Dental Services (CHP+ dental PAHP only)

Detailed provider categories within these high-level groups guided subsequent data review and provider crosswalk development, and HSAG mapped the plans' provider data attributes into preliminary provider crosswalks (i.e., documents describing the logic and data values that would identify providers attributed to each Department-approved category).

HSAG then reconciled the preliminary crosswalk results and collaborated with the Department to review the resulting provider category definitions and finalize the crosswalks. HSAG applied the results of the provider crosswalk to the plans' provider data to conduct the PCA, generating plan-specific frequency counts of total and unique providers for each provider category.

As the study was designed to provide a baseline for future network adequacy validation tasks using existing provider network data and documentation, the plans were not given the opportunity to submit additional information on their providers following the PCA.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2018–2019. 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 quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

Colorado Access (COA)

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-1 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 2018–2019.

Table 3-1—Summary of COA Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**68**	**65**	**3**	**0**	**0**	**96%**

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

Table 3-2 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

Table 3-2—Summary of COA Scores for the FY 2018–2019 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	82	82	0	8	100%
Totals	**190**	**168**	**168**	**0**	**22**	**100%**

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

COA: Strengths

COA's care coordination policies and associated procedures addressed provision of care coordination for all members through either the PCP or COA care coordination staff members and included: criteria for making referrals to and ensuring coordination of services among providers; providing continuity of care for members transitioning between settings of care; and coordinating with multiple providers, agencies, and community organizations for members with complex needs. PCPs were responsible for coordinating care unless the member was identified to COA case management through a health risk assessment (HRA) or referral for assistance with coordinating complex physical, behavioral, and/or or social support needs. COA conducted an HRA shortly after enrollment for all CHP+ members and used results of the initial HRA to stratify members into levels of need for care management. COA care managers developed a service or treatment plan for members with complex problems, serious health conditions, or special health care needs (SHCN) and shared results of the assessment and intervention plans with other entities involved in the member's care. COA allowed direct access to specialists within COA's provider network and arranged through single case agreements an ongoing course of treatment for members with SHCN requiring access to out-of-network specialists.

COA maintained written policies and procedures that addressed member rights afforded to members and member responsibilities. COA distributed the rights to members, employees, and providers through the Evidence of Coverage booklet, Member Benefits Handbook Summary, provider manual, new provider orientation, newsletters, and the COA website. COA had a robust process for monitoring customer service calls to identify any issues of dissatisfaction that may indicate a member rights violation. COA also maintained numerous policies and procedures that addressed nondiscrimination, communication with members with limited English proficiency, cultural awareness strategies, member materials readability guidelines, disability rights, and compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements. COA delineated required advance directive information within its policies, provider manual, and on the COA member and provider websites.

COA's credentialing and recredentialing policies and procedures were well-written, comprehensive, and compliant with NCQA standards and guidelines. COA demonstrated that staff members were credentialing and recredentialing providers and organizations in a manner consistent with written procedures. Credentialing and recredentialing files demonstrated review of all NCQA-required information. COA had a process for ongoing review of Office of Inspector General (OIG) and System for Award Management (SAM) queries. COA also delegated credentialing and recredentialing to several contracted organizations. HSAG reviewed delegation agreements and monitoring processes to ensure adequate oversight of delegated entities. COA retained the right to approve, suspend, or terminate providers approved by any of its delegated entities.

COA's Quality Assessment and Performance Improvement (QAPI) program description defined a robust corporate-wide QAPI program and included a description of COA's organizational structure, goals and objectives, committee composition and roles, and comprehensive QAPI program components. The program description addressed all required QAPI components, including CAHPS measures, HEDIS measures, PIPs, utilization measures, quality of care concerns, clinical guidelines, and care management. The CHP+ PIP met the required design parameters. COA's quality management (QM) department

collaborated with all programmatic areas within COA to drive improvement activities and to collect and distribute data to providers. COA demonstrated through the CHP+ HMO Annual Quality Report that the results, analysis, interventions for improvement, and all CHP+ quality improvement activities were reported to the Department. On-site, COA demonstrated a dashboard of numerous data elements used to monitor and detect over- or underutilization of services. COA's Quality Improvement Committee (QIC) reviewed both quarterly and annual CHP+ quality performance reports. COA had policies and procedures for adopting clinical practice guidelines (CPGs) in compliance with requirements and had CPGs in place for specific CHP+ health conditions as required by the Department. COA provided evidence that CPGs are available to members and providers on the COA website. Staff members described processes for ensuring that decisions in other program areas are consistent with clinical guidelines. COA demonstrated that it has a fully integrated health information system (HIS) and that complete data are stored in its enterprise data warehouse (EDW). Utilization, claims, grievances and appeals, and enrollment and disenrollment data from the EDW could be aggregated, analyzed, and reported to support corporate operations and the QAPI program. The claims processing and retrieval system enabled electronic monthly submission of CHP+ encounter data to the State in the required format. COA's claim and transaction systems applied automated edits and logic to ensure accuracy, timeliness, completeness, and consistency of claims data received from providers. COA reported that manual review is used when necessary to ensure accurate and complete encounter data.

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

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care and Standard VIII—Credentialing and Recredentialing.

Standard IV—Member Rights and Protections

COA's Member Rights and Responsibilities policy directed the reader to the State's rights and responsibilities listed in the Medicaid Managed Care Program section of the CCR. The CCR does not include the complete list of federally-defined member rights. COA was required to:

- Ensure that all required member rights are accounted for within its Member Rights and Responsibilities policy.

Standard X—Quality Assessment and Performance Improvement

COA did not demonstrate that its QAPI program included evaluation of the quality and appropriateness of care provided to members with SHCN. In addition, while the CHP+ HMO Annual Quality Report documented summary results of all quality initiatives undertaken in the FY, neither the report nor the QIC minutes documented statements or conclusions regarding the overall effectiveness of the QAPI program or any of its component activities. COA was required to:

- Implement mechanisms to assess the quality and appropriateness of care furnished to CHP+ members with SHCN.
- Implement an annual process for evaluating the impact and effectiveness of the CHP+ QAPI program.

COA: Trended Performance for Compliance With Regulations

Table 3-3 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 3-3—Compliance With Regulations Trended Performance for COA

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	88%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	91%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**92%**	**100%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**80%**	**88%**
Standard V—Member Information (2014–2015, 2017–2018)	91%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	77%	95%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	100%	100%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*	**94%**	**100%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*	**100%**	**89%**

**Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that COA improved performance in seven of the 10 standards, with the greatest improvement (18 percentage points) observed in Standard VI—Grievance and Appeal System. In one standard area, Standard VII—Provider Participation and Program Integrity, COA maintained 100 percent compliance across review cycles. COA experienced an 11 percent decline from its previous 100 percent performance in Standard X—Quality Assessment and Performance Improvement. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as "NA" for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods. Overall, COA scores demonstrate strong understanding of and compliance with federal managed care regulations and State contract requirements.

Validation of Performance Measures

Compliance With IS Standards

According to COA's 2019 HEDIS Compliance Audit Report, COA was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted COA's HEDIS performance measure reporting.

Performance Measure Results

Table 3-4 shows the performance measure results for COA for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

Table 3-4—Performance Measure Results for COA

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	65.92%	62.30%	71.58%^	25th–49th
Combination 3	63.67%	60.82%	69.58%^	25th–49th
Combination 4	59.71%	58.71%	66.86%^	25th–49th
Combination 5	56.67%	53.96%	63.21%^	50th–74th
Combination 6	38.97%	41.29%	49.53%^	75th–89th
Combination 7	53.76%	52.38%	61.32%^	50th–74th
Combination 8	37.12%	39.92%	48.23%^	75th–89th
Combination 9	35.80%	37.59%	45.64%^	75th–89th
Combination 10	34.35%	36.54%	44.58%^	75th–89th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	70.39%	70.24%	76.30%^	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	31.71%	38.90%^	75th–89th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	2.17%	1.36%	**6.36%^^**	<10th
Six or More Visits	61.96%	59.86%	**47.27%^^**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.48%	69.32%	68.50%	25th–49th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.88%	48.34%	49.87%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	3.85%	5.25%	9.27%^	<10th
Counseling for Nutrition—Total	2.08%	2.94%	5.11%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Counseling for Physical Activity—Total	0.78%	1.06%	3.14%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	84.93%	88.07%	**84.60%^^**	50th–74th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	91.23%	94.65%	**90.30%^^**	<10th
Ages 25 Months to 6 Years	86.24%	85.90%	84.52%	25th–49th
Ages 7 to 11 Years	91.63%	89.74%	87.98%	25th–49th
Ages 12 to 19 Years	92.18%	90.90%	**87.78%^^**	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	32.72%	32.11%	32.27%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.24%	0.06%	0.08%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	0.00%	0.00%	0.00%	<10th
Continuation and Maintenance Phase	0.00%	0.00%	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	29.59%	30.49%	25th–49th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[1]				
Total	4.05%	6.67%	3.23%	25th–49th
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	89.63%	92.12%	93.25%	50th–74th
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Ages 5 to 11 Years	51.18%	65.41%	58.41%	50th–74th
Medication Compliance 50%—Ages 12 to 18 Years	48.31%	55.77%	50.00%	25th–49th
Medication Compliance 75%—Ages 5 to 11 Years	27.56%	34.59%	36.28%	75th–89th
Medication Compliance 75%—Ages 12 to 18 Years	26.97%	27.88%	23.33%	25th–49th
Asthma Medication Ratio[1]				
Ages 5 to 11 Years	87.50%	80.58%	83.19%	≥90th
Ages 12 to 18 Years	74.74%	72.07%	75.79%	≥90th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department (ED) Visits**	26.48	26.36	26.90	≥90th
Outpatient Visits[1]	224.38	221.11	218.12	<10th
Inpatient Utilization—General Hospital/Acute Care[1]				
Discharges per 1,000 Member Months (Total Inpatient)	0.96	0.99	1.03	<10th
Average Length of Stay (Total Inpatient)	3.64	3.74	3.43	<10th
Discharges per 1,000 Member Months (Medicine)	0.66	0.67	0.74	<10th
Average Length of Stay (Medicine)	2.88	2.85	2.97	<10th
Discharges per 1,000 Member Months (Surgery)	0.26	0.28	0.25	<10th
Average Length of Stay (Surgery)	5.79	6.00	4.90	<10th
Discharges per 1,000 Member Months (Maternity)	0.09	0.09	0.09	<10th
Average Length of Stay (Maternity)	2.41†	3.05†	2.58†	<10th
Antibiotic Utilization*				
Average Scripts Per Member Per Year (PMPY) for Antibiotics	0.46	0.42	0.35	≥90th
Average Days Supplied per Antibiotic Script	10.94	10.88	10.87	<10th
Average Scripts PMPY for Antibiotics of Concern	0.16	0.14	0.12	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.77%	34.12%	33.71%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.
— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.
Rated shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

COA: Strengths

The following HEDIS 2019 measure rates were determined to be high performers for COA (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018):

- *Childhood Immunization Status—Combinations 5–10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Medication Management for People With Asthma—Medication Compliance 75%—Ages 5 to 11 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*

For HEDIS 2019, COA demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for seven of 11 (63.6 percent) measure rates and demonstrating significant improvement for all 11 measure rates. Additionally, the MCO demonstrated appropriate management of members with asthma, particularly for children ages 5 to 11 years.

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

The following HEDIS 2019 measure rates were determined to be low performers for COA (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant decline in performance from HEDIS 2018):

- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 12 to 19 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

COA's performance demonstrated opportunities to improve access to the appropriate providers and services for children and adolescents, as evidenced by the rates for well-child/well-care visits, *Children and Adolescents' Access to Primary Care Practitioners*, and *Chlamydia Screening in Women* falling below the 50th percentile. The MCO should work with the Department and providers to identify the causes for the low access to care and preventive screening rates (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved provider training or community outreach and education) and implement strategies to improve the care for young members.

Validation of Performance Improvement Projects

Table 3-5 presents the FY 2018–2019 validation findings for COA's PIP.

Table 3-5—Validation Findings for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 10 through 14 years of age attributed to Metro Community Provider Network (MCPN).
SMART Aim Statement	By June 30, 2020, increase the percentage of well child visits among members 10–14 years of age attributed to MCPN, from 25.28% to 37.18%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 10 through 14 years of age attributed to MCPN during the rolling 12-month measurement period who each received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

COA: Strengths

COA selected a PIP topic focused on increasing the rate of well-child visits among members 10 through 14 years of age. The CHP+ health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, COA will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ health plan will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.

- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

CAHPS Survey

Findings

Table 3-6 shows the results achieved by COA for FY 2016–2017 through FY 2018–2019.

Table 3-6—Question Summary Rates and Global Proportions for COA

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	85.6%	85.3%	87.7%
Getting Care Quickly	90.1%	92.4%	90.5%
How Well Doctors Communicate	95.2%	95.4%	94.8%
Customer Service	86.9%	83.7%	81.9%
Shared Decision Making	83.5%+	74.8%+	79.6%+
Rating of Personal Doctor	73.5%	76.2%	78.0%
Rating of Specialist Seen Most Often	70.2%+	78.9%+	77.1%+
Rating of All Health Care	67.2%	69.1%	67.7%
Rating of Health Plan	61.4%	61.3%	69.3%

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.

COA: Strengths

For COA's CHP+ population, one measure rate increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Health Plan* (8 percentage points)

Three of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Shared Decision Making*
- *Rating of Personal Doctor*

For COA's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Specialist Seen Most Often* (6.9 percentage points)
- *Rating of Health Plan* (7.9 percentage points)

Four of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

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

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

For COA's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Five of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

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

For COA's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Three of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

COA experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, five measurement rates showed slight decreases. HSAG recommends that COA prioritize analysis of what may be driving the decrease in rates from FY 2017–2018 to FY 2018–2019. HSAG offers the following recommendations that COA could consider based on population needs and health plan resources.

The *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. COA could consider the following recommendations:

- Conducting evaluations to assess staff members' and providers' customer service skills and developing training programs designed to address issues found related to both staff members and providers.
- Developing an ongoing tracking mechanism that captures why members called customer service and identifies the most common questions and concerns expressed by members. With this information, COA should develop training directed at those findings to ensure that customer service representatives, call center staff members, and clinic-based reception area staff members have the information and resources needed to address the most common concerns.
- Enhancing weekly or monthly team meetings to include evaluating staff performance during calls in which the content or request was difficult and providing peer support as needed.
- Expanding the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.

Validation of Network Adequacy

COA: Strengths

COA's Provider Data Structure Questionnaire responses noted that COA updates its provider data using the providers' triennial recredentialing information. COA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider. COA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

COA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify providers into applicable BH provider categories.

COA identified prenatal care (PNC) providers as individuals with obstetrics/gynecology (OB/GYN) or nurse midwifery specialties, but also included selected family medicine practitioners who offer OB/GYN services.

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

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. COA also did not indicate that it uses the National Plan and Provider Enumeration System (NPPES) Registry, the American Board of Medical Specialties board certification database, or the providers' CHCP applications to validate providers' type and specialty information.

Although COA consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, COA did not restrict these data indicators by degree or credential. Further, COA reported that it does not collect providers' taxonomy codes and COA's data included similar, but not identical, data values for the provider type and specialty fields. These factors complicated HSAG's efforts to map COA's provider data to the Department's provider categories.

As the first comprehensive review of COA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing COA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, COA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Denver Health Medical Plan, Inc. (DHMP)

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-7 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

Table 3-7—Summary of DHMP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	6	3	1	0	60%
Standard IV—Member Rights and Protections	8	8	8	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	30	30	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**66**	**60**	**5**	**1**	**2**	**91%**

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

Table 3-8 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

Table 3-8—Summary of DHMP Scores for the FY 2018–2019 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	85	85	0	15	100%
Recredentialing	90	84	84	0	6	100%
Totals	**190**	**169**	**169**	**0**	**21**	**100%**

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

DHMP: Strengths

DHMP care coordination for CHP+ members was primarily delivered through the system-wide care coordination resources, tools, and programs of the Denver Health and Hospitals Authority (DHHA) clinic delivery system. Documents submitted delineated criteria for making referrals among various programs and providers. DHHA had mechanisms to coordinate care between different settings of care, with services provided through external entities, and with community and social support organizations. DHHA's Care Management program and/or its designated pediatric specialty clinic staff members had a process to conduct comprehensive needs assessments and develop service plans for members with SHCN. DHMP allowed members with SHCN to directly access specialists through a standing referral or a preauthorized number of visits. Care coordination assessments, plans, interventions, and referrals were documented and communicated through the Epic electronic health record (EHR) system, available to all DHHA providers and care coordination staff members, as well as approved external provider entities.

DHMP's policies and procedures that addressed member rights and protections included a list of all federally mandated CHP+ member rights, which were also well-articulated in the CHP+ member handbook and provider manual. DHMP policies and procedures addressed providing DHMP staff members and providers initial and annual training regarding member rights. DHMP had robust policies, procedures, and organizational practices to ensure members' privacy and confidentiality rights under HIPAA. Policies and procedures adequately addressed federal regulations related to advance directives, and DHMP's website included information regarding advance directives.

DHMP had a well-defined credentialing and recredentialing program that met all NCQA standards. On-site record reviews confirmed that DHMP implemented processes compliant with all NCQA credentialing and recredentialing requirements for practitioners and organizational providers. DHMP conducted ongoing monitoring of federal exclusion databases to ensure practitioners and providers had not been excluded from federal healthcare participation. DHMP had a delegation agreement with DHHA for credentialing and recredentialing practitioners that served CHP+ members through DHHA clinics and facilities. DHMP demonstrated that it provided oversight to ensure the quality and completeness of DHHA's credentialing and recredentialing activities.

DHMP's Quality Improvement (QI) Program Description and QI Impact Analysis demonstrated that it had a comprehensive QAPI program in place. The QAPI program was conducted in partnership with DHHA and addressed the availability and adequacy of services, CPGs, continuity and coordination of care, investigation of quality of care complaints, PIPs, HEDIS measures, and CAHPS measures. DHMP demonstrated that all CHP+ QAPI activities and data were reported to the Department as required. DHMP had policies and procedures for adopting CPGs in compliance with requirements and had practice guidelines in place for specific CHP+ health conditions as required by the Department. DHMP distributed practice guidelines to providers through the DHHA intranet, targeted mailings, and the DHMP website. HIS documents demonstrated that DHMP had access to a robust, enterprise-wide DHHA information system with well-integrated components, allowing DHMP to access all necessary data for management of the health plan. DHMP claims systems electronically and manually verified claims data received from providers for completeness, coding accuracy and appropriateness, and service authorizations. DHMP monthly submitted electronic batch encounter data to the Department in required formats.

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

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections and Standard VIII—Credentialing and Recredentialing.

Standard III—Coordination and Continuity of Care

DHMP did not have a process in place to ensure that all newly enrolled CHP+ members needing continuity of care were identified and that services to prevent disruption in care were provided as needed. DHMP did not have an active mechanism to ensure that each CHP+ member has an ongoing source of primary care—e.g., a PCP. DHMP also did not have procedures in place to conduct an initial assessment of each new CHP+ member's needs that included all State-required initial assessment elements. While DHHA's Care Management program included a comprehensive assessment of members with SHCN when members were referred to the Care Management program, mechanisms were unclear regarding how CHP+ members with SHCN were identified and referred to DHHA's Care Management program. DHMP was required to:

- Define and implement procedures for providing continuity of care for newly enrolled CHP+ members to prevent disruption in the provision of medically necessary services.
- Implement mechanisms to ensure that each CHP+ member has an ongoing source of primary care and that DHMP provides information to the member on how to contact his or her PCP.
- Implement a mechanism to conduct an initial screening of each CHP+ member's health needs within 90 days of enrollment. The initial screening must include assessment of mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health needs.
- Ensure that each member with SHCN is consistently identified and receives a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Standard X—Quality Assessment and Performance Improvement

DHMP did not demonstrate that it has a mechanism for detection or analysis of under- or overutilization of services as a component of the QAPI program. While DHMP had operational processes targeted toward enhancing the quality of care delivered to individual members with SHCN, DHMP did not demonstrate that it periodically assesses the overall quality of care being delivered to members with SHCN. DHMP was required to:

- Incorporate mechanisms to detect both under- and overutilization of services into its QAPI program.
- Develop and implement mechanisms within its QAPI program to assess the overall quality and appropriateness of care provided to CHP+ members with SHCN.

DHMP: Trended Performance for Compliance With Regulations

Table 3-9 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 3-9—Compliance With Regulations Trended Performance for DHMP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	81%	92%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**100%**	**60%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**100%**	**100%**
Standard V—Member Information (2014–2015, 2017–2018)	91%	83%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	81%	91%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	100%	79%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*	**98%**	**100%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*	**93%**	**89%**

**Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that DHMP improved performance in four of the 10 standards: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievance and Appeal System, and Standard VIII—Credentialing and Recredentialing, with approximately a 10 percentage point increase in three of those standards. In two standard areas, Standard IV—Member Rights and Protections and Standard X—Credentialing and Recredentialing, DHMP maintained consistent compliance at or near 100 percent. DHMP experienced slight declines in performance—less than 10 percent—in two standards, Standard V—Member Information and Standard X—Quality Assessment and Performance, and experienced substantial declines in Standard III—Coordination and Continuity of Care (40 percentage points) and Standard VII—Provider Participation and Program Integrity (21 percentage points). Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as "NA" for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

Validation of Performance Measures

Compliance With IS Standards

According to DHMP's 2019 HEDIS Compliance Audit Report, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted DHMP's HEDIS performance measure reporting.

Performance Measure Results

Table 3-10 shows the performance measure results for DHMP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

Table 3-10—Performance Measure Results for DHMP

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	73.28%	BR	67.46%	10th–24th
Combination 3	73.28%	BR	65.87%	25th–49th
Combination 4	73.28%	BR	65.87%	25th–49th
Combination 5	67.24%	BR	57.94%	25th–49th
Combination 6	53.45%	BR	46.03%	50th–74th
Combination 7	67.24%	BR	57.94%	25th–49th
Combination 8	53.45%	BR	46.03%	50th–74th
Combination 9	50.86%	BR	41.27%	50th–74th
Combination 10	50.86%	BR	41.27%	75th–89th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	72.06%	68.81%	82.24%^	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	—	49.54%	55.92%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	6.78%	NA	15.15%	<10th
Six or More Visits	6.78%	NA	63.64%	25th–49th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.48%	46.64%	64.74%^	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	41.37%	37.64%	45.30%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	7.94%	17.71%	21.80%^	<10th
Counseling for Nutrition—Total	1.46%	6.41%	7.93%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Counseling for Physical Activity—Total	0.80%	1.40%	6.65%^	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	83.87%	NA	83.33%	50th–74th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	93.98%	69.03%	90.36%^	<10th
Ages 25 Months to 6 Years	71.52%	57.24%	73.58%^	<10th
Ages 7 to 11 Years	85.65%	81.33%	86.93%^	10th–24th
Ages 12 to 19 Years	85.48%	78.05%	82.04%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	56.06%	39.74%	47.22%	25th–49th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	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				
Total	—	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	91.40%	100.00%	100.00%	≥90th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*ED Visits**	18.09	18.43	21.49	≥90th
Outpatient Visits[1]	117.49	123.51	135.56	<10th
Inpatient Utilization—General Hospital/Acute Care[1]				
Discharges per 1,000 Member Months (Total Inpatient)	0.88	0.69	0.82	<10th
Average Length of Stay (Total Inpatient)	2.80	4.25	3.07	<10th
Discharges per 1,000 Member Months (Medicine)	0.65	0.49	0.60	<10th
Average Length of Stay (Medicine)	2.68	2.90	2.59	<10th
Discharges per 1,000 Member Months (Surgery)	0.21	0.18	0.17	<10th
Average Length of Stay (Surgery)	2.92†	8.07†	5.07†	<10th
Discharges per 1,000 Member Months (Maternity)	0.03	0.02	0.09	<10th
Average Length of Stay (Maternity)	6.00†	2.00†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.13	0.09	0.14	≥90th
Average Days Supplied per Antibiotic Script	10.47	12.07	11.28	<10th
Average Scripts PMPY for Antibiotics of Concern	0.03	0.02	0.03	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	26.07%	23.31%	24.04%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.
† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

DHMP: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for DHMP:

- *Childhood Immunization Status—Combination 10*

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

DHMP showed strong performance with vaccinating children and adolescents for HEDIS 2019 by ranking above the 50th percentile for six of 11 (54.5 percent) measure rates and by demonstrating improvement and exceeding the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator. Additionally, the MCO continued to demonstrate strength ensuring providers are not overusing inappropriate treatments for members with respiratory infections and not screening young women unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for DHMP:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*

Despite demonstrating significant improvement for seven of 11 (63.6 percent) measure rates determined to be low performers for HEDIS 2019, DHMP continued to demonstrate opportunities to improve access to preventive care and services for children and adolescents. The MCO and the Department should identify the factors contributing to the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.[3-16]

[3-16] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Jul 16, 2019.

Validation of Performance Improvement Projects

Table 3-11 presents the FY 2018–2019 validation findings for DHMP's PIP.

Table 3-11—Validation Findings for the *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Webb Pediatrics Patient-Centered Medical Home (PCMH).
SMART Aim Statement	By June 30, 2020, increase the percentage of Denver Health CHP+ Members aged 15–18 assigned to the Webb Pediatrics PCMH who attend at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner year from 54.36% to 66.44%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of Denver Health CHP+ members ages 15 through 18 as of the last day of each rolling 12-month measurement period assigned to the Webb Pediatrics PCMH, and who attended at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner within each rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims and electronic medical record (EMR) data. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

DHMP: Strengths

DHMP selected a PIP topic focused on increasing the rate of well-care visits among members 15 through 18 years of age. The CHP+ health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that DHMP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. DHMP has progressed to Module 3, where the CHP+ health plan will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, DHMP will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ health plan will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As DHMP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on

impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

CAHPS Survey

Findings

Table 3-12 shows the results achieved by DHMP for FY 2016–2017 through FY 2018–2019.

Table 3-12—Question Summary Rates and Global Proportions for DHMP

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	75.8%	83.5%	79.7%
Getting Care Quickly	80.6%	88.4%	85.0%
How Well Doctors Communicate	96.5%	95.6%	94.4%
Customer Service	81.4%	84.4%	87.8%
Shared Decision Making	74.8%+	72.5%+	72.8%+
Rating of Personal Doctor	80.3%	84.6%	75.7%
Rating of Specialist Seen Most Often	77.4%+	84.1%+	85.3%+
Rating of All Health Care	67.8%	70.2%	69.2%
Rating of Health Plan	67.4%	65.3%	65.4%

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.

DHMP: Strengths

For DHMP's CHP+ population, no measure rates increased substantially between FY 2017–2018 and FY 2018–2019.

Four of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

For DHMP's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Customer Service* (6.4 percentage points)
- *Rating of Specialist Seen Most Often* (7.9 percentage points)

Three of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Rating of All Health Care*

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

For DHMP's CHP+ population, one measure rate decreased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Personal Doctor* (8.9 percentage points)

Four of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*

For DHMP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

DHMP experienced one substantial score decrease in FY 2018–2019 compared to the previous year. Additionally, four measure rates showed slight decreases compared to the previous year. HSAG recommends that DHMP prioritize analysis of what may be driving the decrease in the *Rating of Personal Doctor* rate from FY 2017–2018 to FY 2018–2019. However, to improve member perception for this measure, and others that demonstrated a decrease from FY 2017–2018 to FY 2018–2019, HSAG offers the following recommendations for DHMP to consider based on population needs and health plan resources.

The *Rating of Personal Doctor, Getting Needed Care*, *Getting Care Quickly, How Well Doctors Communicate*, and *Rating of all Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG recommends that DHMP:

- Conduct evaluations to assess staff members' and providers' customer service skills, and develop training programs designed to address issues found for both staff members and providers.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Ensure continued ongoing communication to remind members, providers, and call center staff members of timeliness access standards and where to access after-hours care.
- Consider expanding the contracted provider network for primary care as well as specialists.
- Consider further expanding use of walk-in clinics and services and provide members and families ongoing reminders of where to access walk-in care.
- Evaluate the effectiveness of current processes for telephonic or other technology-based communications with members that provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluate scheduling mechanisms related to CHP+ timely access to appointment standards, perhaps including assessment and training of schedulers to assess the urgency of an appointment request; and providing schedulers with CHP+ specific information to direct members to alternative sources of service when appropriate.

- Develop provider training forums or procedures that encourage providers to verify or ensure that members understand communications.
- Explore creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, or offering member mentorship programs.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

Validation of Network Adequacy

DHMP: Strengths

DHMP's Provider Data Structure Questionnaire responses noted that DHMP updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. DHMP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the DHMP data system, these individual providers were not listed on provider network rosters. DHMP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

DHMP reported including Denver Public Health within its provider network, facilitating identification of providers who serve members with clinical conditions of public health importance.

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

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although DHMP noted using the self-reported provider specialty information to identify PCPs or PNC providers, DHMP did not restrict these data indicators by degree or credential. Additionally, DHMP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map DHMP's provider data to the Department's provider categories. Further, DHMP reported that panel capacity information was not available in its provider data system, though DHMP did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by DHMP included no records for substance abuse treatment facilities.

As the first comprehensive review of DHMP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing DHMP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, DHMP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Friday Health Plans of Colorado (FHP)

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-13 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 2018–2019.

Table 3-13—Summary of FHP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	9	9	7	2	0	0	78%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	28	24	4	0	4	86%
Standard X—Quality Assessment and Performance Improvement	18	18	15	1	2	0	83%
Totals	**67**	**63**	**53**	**8**	**2**	**4**	**84%**

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

Table 3-14 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

Table 3-14—Summary of FHP Scores for the FY 2018–2019 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	93	90	3	7	97%
Recredentialing	90	87	87	0	3	100%
Totals	**190**	**180**	**177**	**3**	**10**	**98%**

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

FHP: Strengths

FHP integrated CHP+ members into its medical management and services coordination processes applicable to all FHP lines of business. FHP's HRA, administered to members on enrollment, included all required screening indicators to identify CHP+ members with SHCN and/or in need of continuity of care or coordination services. FHP reported that its small CHP+ population included very few members with ongoing complex medical or behavioral needs. FHP provided evidence that it performed a comprehensive assessment, developed a service plan for members identified as having special needs, and shared the assessment and service plan with providers and other entities involved in the member's care. The provider manual instructed providers to share results of assessments and members' treatment plans with other providers. Due to the small CHP+ population, staff members stated that FHP widely uses interpersonal interactions and relationships with providers and other entities to manage care for CHP+ members.

FHP's Member Rights and Responsibilities policy and procedure required all employees and providers to comply with all applicable federal and State laws related to member rights and listed specific CHP+ member rights. FHP included member rights in the CHP+ member handbook and provider manual. FHP requires that all employees participate in member rights training at time of hire. FHP notified providers about their responsibility to take member rights into account when furnishing services via the provider contract and provider manual. Customer service staff members participated in weekly meetings to identify and address any issues related to member rights. FHP had a robust HIPAA privacy policy and procedure for ensuring appropriate protection of personal health information. FHP had a well-written, comprehensive desktop procedure that addressed requirements related to advance directives and staff and member education related to advance directives. FHP demonstrated that it conducts annual CHP+ chart reviews that include review of advance directive requirements.

FHP's Credentialing Plan was compliant with NCQA requirements and guidelines and delineated the types of practitioners and facilities subject to credentialing and recredentialing, the criteria for joining

the FHP network, and credentialing verification sources used. FHP delegated no NCQA-required credentialing and recredentialing activities. The Credentialing Plan described the roles of credentialing staff members, the medical director, and the credentialing committee. FHP provided evidence of processes for ongoing monitoring for practitioner Medicare and Medicaid sanctions, complaints, and quality issues between recredentialing cycles.

FHP's Quality Assurance Plan demonstrated that FHP has an ongoing comprehensive QAPI program applicable to CHP+ members. FHP had many resources dedicated to QAPI activities: an established organizational structure, established organizational processes related to each component of the program, and oversight of the program by two quality improvement committees. Due to the relatively small CHP+ population, FHP integrated CHP+ members into all of its health plan-wide QAPI activities. Physician Advisory Committee minutes confirmed that QAPI program components included peer review, medical record review, credentialing, review of authorization outcomes, assessment of quality of care concerns, review of grievance and appeal activity, and clinical input into quality improvement activities. FHP participated in PIPs, HEDIS performance measures, and CAHPS surveys, which were compliant with all related requirements. The Quality Management Program Committee (QMPC) reviewed results of member surveys, grievances, and HEDIS measures and initiated internal corrective action plans as indicated. The Quality Assurance Plan outlined well-defined criteria for annual evaluation of overall effectiveness of the QAPI program. FHP had processes for adopting CPGs in compliance with requirements and had practice guidelines in place for specific CHP+ health conditions as required by the Department. FHP disseminated practice guidelines to members and providers through its website. FHP demonstrated that its HIS collects, integrates, analyzes, and reports data in compliance with federal managed care requirements. FHP's claims processing systems collect all required data to enable monthly encounter data submission to the Department in the required format. FHP employed automated system edits and manual screenings of claims data from providers to ensure accuracy, timeliness, completeness, and coding logic of claim information. FHP's HIS adequately performed all required health information functions.

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

Standard III—Coordination and Continuity of Care

FHP's policies and procedures outlined processes for ensuring delivery of care and coordination of services but did not address the requirement that all CHP+ members or family members consent to the medical treatment plan. In addition, while FHP preferred to coordinate care with other healthcare plans through the member's provider, FHP did not have procedures to directly coordinate services being received by CHP+ members with other managed care and FFS health plans or when the member is transitioning between health plans. FHP was required to:

- Define procedures to ensure that CHP+ members and/or authorized family members are involved in treatment planning and consent to any medical treatment.
- Develop and implement procedures to directly coordinate services being received by CHP+ members with other managed care and FFS health plans when indicated.

Standard IV—Member Rights and Protections

FHP's Notification of Advance Directives desktop procedure included no provisions for providing information regarding advance directives to an adult member's family or surrogate if the member is incapacitated at the time of initial enrollment. FHP was required to:

- Convert its desktop procedure into a more formal policy and procedure and revise its processes to include provisions for providing information regarding advance directives to an adult CHP+ member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder.

Standard VIII—Credentialing and Recredentialing

While FHP's credentialing and recredentialing policies and procedures described processes that were consistent with NCQA Standards and Guidelines, on-site record reviews documented several cases in which FHP did not comply with its policies and procedures. Examples included: accepting a provider into the network prior to receiving the provider applicant's signed attestation, accepting providers into the network prior to federal sanction information being received, and failing to recredential organizational providers within the required 36-month time frame. In addition, while review of organizational credentialing files demonstrated that FHP adhered to the requirement for using CMS or State quality reviews in lieu of site visits, this process was not documented in FHP's Credentialing Plan. FHP was required to:

- Ensure that staff members collect signed attestations from provider applicants prior to accepting the provider into the network.
- Ensure that a provider is not accepted into the network prior to information from federal exclusion databases being received and reviewed.
- Ensure that staff members recredential organizational providers every 36 months.
- Revise its credentialing process documentation to include the NCQA requirements related to on-site quality assessment for unaccredited organizational providers.

Standard X—Quality Assessment and Performance Improvement

While FHP applied internal operational processes—i.e., coordination of services—to enhance the quality and appropriateness of care for individual CHP+ members with SHCN, FHP had no mechanism within its QAPI program to assess the overall quality and appropriateness of care furnished to these members. While FHP has a well-defined approach for adopting and disseminating CPGs in compliance with requirements, FHP did not demonstrate having an internal process for ensuring that other decisions to which the guidelines apply are consistent with adopted practice guidelines. While FHP demonstrated having the capability to produce on-demand utilization data trending reports, HSAG found no evidence that these types of reports were reviewed or that data were sufficiently analyzed within the QAPI program to determine potential under- or overutilization of services. FHP was required to:

- Implement a mechanism within its QAPI program to periodically assess quality and appropriateness of care for members with SHCN.
- Define and implement a process to ensure that utilization management (UM) decisions, member education materials, and other areas to which practice guidelines apply are consistent with adopted practice guidelines.
- Define and implement mechanisms within the QAPI program to systematically detect and determine concerns regarding both underutilization and overutilization of services.

FHP: Trended Performance for Compliance With Regulations

Table 3-15 displays FHP'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 3-15—Compliance With Regulations Trended Performance for FHP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	71%	91%
Standard II—Access and Availability (2013–2014, 2016–2017)	73%	79%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**50%**	**78%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**80%**	**88%**
Standard V—Member Information (2014–2015, 2017–2018)	74%	92%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	27%	82%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	69%	93%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*	**77%**	**86%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	60%	NA
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*	**73%**	**83%**

**Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that FHP improved performance in nine of the 10 standards, with the greatest improvement (55 percentage points) observed in Standard VI—Grievance and Appeal System and substantial improvements (18 percentage points to 28 percentage points) in Standard I—Coverage and Authorization, Standard III—Coordination and Continuity of Care, Standard V—Member Information, and Standard VII—Provider Participation and Program Integrity. FHP also demonstrated improvement (10 percentage points or less) in four additional standards: Standard II—Access and Availability, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as "NA" for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG

cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods. Over the six-year cycle of compliance reviews, FHP has consistently demonstrated increased understanding and implementation of compliance with managed care regulations.

Validation of Performance Measures

Compliance With IS Standards

According to FHP's 2019 HEDIS Compliance Audit Report, FHP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted FHP's HEDIS performance measure reporting.

Performance Measure Results

Table 3-16 shows the performance measure results for FHP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

Table 3-16—Performance Measure Results for FHP

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	4.08%	7.84%	4.76%	<10th
Combination 3	4.08%	5.88%	4.76%	<10th
Combination 4	2.04%	3.92%	4.76%	<10th
Combination 5	0.00%	0.00%	4.76%	<10th
Combination 6	2.04%	3.92%	0.00%	<10th
Combination 7	0.00%	0.00%	4.76%	<10th
Combination 8	0.00%	1.96%	0.00%	<10th
Combination 9	0.00%	0.00%	0.00%	<10th
Combination 10	0.00%	0.00%	0.00%	<10th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	14.81%	15.94%	26.32%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	—	5.80%	12.28%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	NA	NA	—
Six or More Visits	NA	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	42.18%	43.72%	55.62%^	<10th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	28.92%	25.05%	37.65%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	1.53%	1.69%	9.70%^	<10th
Counseling for Nutrition—Total	3.44%	5.92%	4.65%	<10th
Counseling for Physical Activity—Total	4.01%	3.38%	6.26%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	74.07%	77.55%	81.16%	50th–74th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	79.41%	NA	NA	—
Ages 25 Months to 6 Years	65.12%	65.33%	71.90%	<10th
Ages 7 to 11 Years	72.61%	73.58%	87.18%^	10th–24th
Ages 12 to 19 Years	76.50%	80.49%	86.43%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	NA	13.95%	NA	—
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	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				
Total	—	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	83.72%	87.72%	92.63%	50th–74th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*ED Visits**	15.26	15.98	17.33	≥90th
Outpatient Visits[1]	176.00	175.38	166.81	<10th
Inpatient Utilization—General Hospital/Acute Care[1]				
Discharges per 1,000 Member Months (Total Inpatient)	0.81	0.65	0.37	<10th
Average Length of Stay (Total Inpatient)	2.56†	2.13†	2.33†	<10th
Discharges per 1,000 Member Months (Medicine)	0.54	0.45	0.21	<10th
Average Length of Stay (Medicine)	2.25†	2.36†	2.00†	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.16	0.17	<10th
Average Length of Stay (Surgery)	3.17†	1.50†	1.50†	<10th
Discharges per 1,000 Member Months (Maternity)	NA	0.08	0.00	<10th
Average Length of Stay (Maternity)	NA	2.00†	NA	—
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.50	0.97	12.00	<10th
Average Days Supplied per Antibiotic Script	12.39	16.68	99.95	<10th
Average Scripts PMPY for Antibiotics of Concern	0.20	0.41	2.32	<10th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	39.01%	41.62%	19.35%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

FHP: Strengths

The following HEDIS 2019 measure rate was determined to be a high performer (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for FHP:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

FHP continued to demonstrate strong performance in ensuring young women were not unnecessarily screened for cervical cancer, with the *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate exceeding the 90th percentile. Additionally, the MCO demonstrated improvement from the prior year and ranked above the 50th percentile for measures related to the appropriate testing and treatment of respiratory infections.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for FHP:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years*

FHP's performance demonstrated opportunities to improve access to preventive care and services for children and adolescents, with the reportable rates for well-child/well-care visits and *Children and Adolescents' Access to Primary Care Practitioners* below the 50th percentile. Further, all *Childhood Immunization Status*, *Immunizations for Adolescents*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* rates were below the 10th percentile for HEDIS 2019, indicating the MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive

comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.[3-17]

Validation of Performance Improvement Projects

Table 3-17 presents the FY 2018–2019 validation findings for FHP's PIP.

Table 3-17—Validation Findings for the *Well-Child Visits in the 6th Through 14th Years of Life* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 6 through 14 years of age attributed to San Luis Valley Health.
SMART Aim Statement	By 6/30/2020, we will increase the percentage of members who meet the eligibility requirements during the measurement period receiving their well-child exam at San Luis Valley Health between the ages of 6 to 14 from 38% to 45%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 6 through 14 years of age attributed to San Luis Valley Health during the rolling 12-month measurement period who each received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

FHP: Strengths

FHP selected a PIP topic focused on increasing the rate of well-child visits among members 6 through 14 years of age. The MCO has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that FHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. FHP has progressed to Module 3, where the MCO will determine potential interventions to test for the PIP.

FHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

In the next phase of the PIP, FHP will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test

[3-17] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Jul 16, 2019.

and refine interventions to achieve the goal for the project. As FHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

CAHPS Surveys

Findings

Table 3-18 shows the results achieved by FHP for FY 2016–2017 through FY 2018–2019.

Table 3-18—Question Summary Rates and Global Proportions for FHP

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	87.9%	86.1%	90.1%+
Getting Care Quickly	93.7%	89.9%	91.0%+
How Well Doctors Communicate	96.5%	95.3%	92.9%
Customer Service	76.9%+	82.0%+	84.0%+
Shared Decision Making	81.8%+	84.6%+	80.4%+
Rating of Personal Doctor	66.4%	62.3%	71.0%
Rating of Specialist Seen Most Often	62.5%+	67.6%+	71.1%+
Rating of All Health Care	54.5%	52.2%	50.6%
Rating of Health Plan	46.7%	47.4%	55.2%

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.

FHP: Strengths

For FHP's CHP+ population, two measure rates increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Personal Doctor* (8.7 percentage points)
- *Rating of Health Plan* (7.8 percentage points)

Four of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Rating of Specialist Seen Most Often*

For FHP's CHP+ population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Customer Service* (7.1 percentage points)
- *Rating of Specialist Seen Most Often* (8.6 percentage points)
- *Rating of Health Plan* (8.5 percentage points)

Two of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Rating of Personal Doctor*

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

For FHP's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Three of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*

For FHP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*

FHP experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, three measurement rates showed slight decreases. HSAG recommends that FHP prioritize analysis of what may be driving the decrease in rates from FY 2017–2018 to FY 2018–2019. HSAG offers the following recommendations that FHP could consider based on population needs and health plan resources.

The *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of All Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. FHP could consider the following recommendations:

- Conduct evaluations to assess staff members' and providers' customer service skills, and develop training programs designed to address issues found related to both staff members and providers.
- Expanding the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Exploring creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, or offering member mentorship programs.

Validation of Network Adequacy

FHP: Strengths

FHP's Provider Data Structure Questionnaire responses noted that FHP updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. While providers with single case agreements were identified within the FHP data system, these individual providers were not listed on provider network rosters. FHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

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

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although FHP noted using the self-reported provider specialty information to identify PCPs or PNC providers, FHP did not restrict these data indicators by degree or credential. Additionally, FHP's data included similar, but not identical, data values for the provider specialty fields, complicating HSAG's efforts to map FHP's provider data to the Department's provider categories. Further, FHP reported that panel capacity information was not available in its provider data system, though FHP did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by FHP included no records for substance abuse treatment facilities, no provider type values, and offered limited specialty values for facility-level providers (e.g., hospitals).

As the first comprehensive review of FHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing FHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, FHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Kaiser Permanente Colorado (Kaiser)

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-19 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 2018–2019.

Table 3-19—Summary of Kaiser Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	8	2	0	0	80%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	30	30	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**66**	**61**	**5**	**0**	**2**	**92%**

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

Table 3-20 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

Table 3-20—Summary of Kaiser Scores for the FY 2018–2019 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	96	96	0	4	100%
Recredentialing	90	87	87	0	3	100%
Totals	**190**	**183**	**183**	**0**	**7**	**100%**

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

Kaiser: Strengths

All CHP+ members received healthcare services through Kaiser's employed and affiliate specialists and hospital provider network. Kaiser demonstrated that it has system-wide resources dedicated to care coordination, which included numerous primary care clinic-based services supplemented by the pediatric care coordination and complex case management programs. Care managers coordinated with multiple providers, agencies, and community organizations, as indicated, and demonstrated processes for active coordination of services between multiple settings of care. Kaiser had a process in place to outreach to new members to ensure that each member has an ongoing source of primary care and to conduct an initial needs assessment. Pediatric care coordination and complex case management programs had procedures to conduct comprehensive assessments, develop a service plan, and coordinate needed services for members with SHCN. Kaiser used its HealthConnect EHR system as the primary mechanism for documenting and communicating referrals, assessments, and treatment or service plans to all network providers. Kaiser had a process for allowing all members to self-refer and directly access any internal Kaiser specialist and for staff members to arrange for long-term approvals and referrals to out-of-network specialists when required.

Kaiser's policies and procedures and internal documents that addressed member rights and protections included all federally mandated CHP+ member rights. Member rights were also well-articulated in the CHP+ member handbook and the provider manual. Kaiser had processes for ensuring that member written communications were provided in alternative formats and easy-to-understand language. Kaiser also had robust policies, procedures, and organizational practices to ensure privacy and confidentiality rights under HIPAA. In addition, policies and procedures adequately addressed federal regulations related to advance directives, and information regarding advance directives was available on Kaiser's website.

Kaiser demonstrated that it had a well-defined credentialing and recredentialing program that was compliant with all NCQA standards and guidelines for credentialing practitioners and assessing contracted organizational providers. Kaiser had delegation agreements with the Kaiser Permanente Medical Group for credentialing and recredentialing practitioners and organizational providers associated with Kaiser's clinics and facilities and with University Physicians, Incorporated. Kaiser provided evidence of adequate oversight to ensure the quality and completeness of both medical groups' credentialing and recredentialing activities.

Kaiser's system-wide QAPI documents described a multilevel, extensive process for oversight and analysis of the quality of services furnished to CHP+ members. The QAPI program specific to CHP+ members focused on CHP+ PIPs, CHP+ HEDIS measures, CAHPS data, quality of care concerns, and grievances and appeals. Kaiser's CHP+ PIP met the required design parameters. Kaiser trended quarterly grievance and appeal data and quality of care concerns. CHP+ members were also included in the system-wide Kaiser QAPI program, which included QAPI measures and initiatives applicable to the entire Kaiser population. The regional Service, Quality, and Resource Management Committee (SQRMC) provided oversight of the integrated patient care quality program. Kaiser demonstrated that the SQRMC annually evaluated the structure and effectiveness of the integrated patient care quality program. Kaiser had policies and procedures for the development of CPGs in compliance with

requirements and had adopted practice guidelines for specific CHP+ health conditions as required by the Department. Guidelines were posted for clinicians on the internal website and were embedded into the automated "smart-sets" in the EHR. Staff members stated that members could access clinical care guidelines during treatment visits to a clinic or through the Kaiser website. Documents submitted described multiple data systems that collect data from various clinical and business points of contact throughout the Kaiser system, exchanging information with external providers and organizations, and compiling data in the system-wide data warehouse. Kaiser's HIS integrated claims data from multiple sources for adjudication of the claim. Kaiser applied automated and manual claims edits to verify completeness, accuracy, coding appropriateness, logic, and consistency of claims, and submitted monthly encounter data to the Department in required formats.

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

HSAG identified no opportunities for improvement that resulted in required actions related to Standard VIII—Credentialing and Recredentialing.

Standard III—Coordination and Continuity of Care

While Kaiser provided information indicating that it has various points of service through which the need for continuity of care for newly enrolled members may be identified, HSAG found potential gaps in the processes to identifying a member to a provider that would ensure provision of necessary services for continuity of care. In addition, while Kaiser had mechanisms for conducting an initial screening of each new member's needs, the assessment did not include all CHP+ contract-required categories of need. Kaiser was required to:

- Enhance procedures for providing continuity of care to newly enrolled members to ensure that any member identified as having continuity of care needs receives timely follow-up by providers or staff members to prevent disruption in provision of services.
- Define and implement a process to conduct an initial assessment of each new member's needs (within 90 days of enrollment) that incorporates screening for all CHP+ required categories of need—mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.

Standard IV—Member Rights and Protections

The description of member rights in member and provider materials related to the member's right to "receive information in accordance with information requirements (42 CFR §438.10)" did not articulate requirements about *how* member information must be presented by the MCO—i.e., in a language and format that would be best understood by the member. Kaiser was required to:

- Clarify the statement of member rights in member and provider materials to state that members have the right to receive information from the MCO in plain language, in English or an alternative

language if preferred by the member, and in a way that takes the member's communication needs into consideration.

Standard X—Quality Assessment and Performance Improvement

While Kaiser described tracking multiple utilization indicators throughout the delivery system, Kaiser did not produce evidence that the described utilization tracking processes resulted in an assessment or determination of over- or underutilization of specific services as a component of the QAPI program. Kaiser was required to:

- Provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the QAPI program and analyzed as such.

Kaiser: Trended Performance for Compliance With Regulations

Table 3-21 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 3-21—Compliance With Regulations Trended Performance for Kaiser

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	91%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	95%	93%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**75%**	**80%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**60%**	**88%**
Standard V—Member Information (2014–2015, 2017–2018)	52%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	65%	68%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	88%	87%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*	**100%**	**100%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*	**67%**	**89%**

**Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that Kaiser substantially improved performance in three standards: Standard IV—Member Rights and Protections (28 percentage points), Standard V—Member Information (48 percentage points), and Standard X—Quality Assessment and Improvement (22 percentage points). Kaiser also demonstrated slight improvement (5 percentage points or less) in three additional standards: Standard I—Coverage and Authorization of Services, Standard III—Coordination and Continuity of Care, and Standard VI—Grievance and Appeal System. Although Kaiser demonstrated

slight improvement in Standard VI—Grievance and Appeal System, results remained consistently low (from 65 percentage points to 68 percentage points) over the two review periods. Kaiser maintained consistent compliance (variance of 2 percentage points or less) in Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, and Standard VIII—Credentialing and Recredentialing. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as "NA" to CHP+ MCOs in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

Validation of Performance Measures

Compliance With IS Standards

According to Kaiser's 2019 HEDIS Compliance Audit Report, Kaiser was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted Kaiser's performance measure reporting.

Performance Measure Results

Table 3-22 shows the performance measure results for Kaiser for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

Table 3-22—Performance Measure Results for Kaiser

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	79.34%	70.85%	69.46%	10th–24th
Combination 3	78.93%	70.17%	67.36%	25th–49th
Combination 4	78.93%	69.15%	66.95%	25th–49th
Combination 5	72.31%	62.03%	62.76%	50th–74th
Combination 6	50.41%	43.73%	41.84%	50th–74th
Combination 7	72.31%	61.02%	62.34%	50th–74th
Combination 8	50.41%	43.39%	41.84%	50th–74th
Combination 9	47.11%	39.32%	40.59%	50th–74th
Combination 10	47.11%	38.98%	40.59%	50th–74th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	86.02%	82.30%	82.84%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	—	53.98%	56.44%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	2.53%	2.91%	2.02%	25th–49th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Six or More Visits	67.09%	66.02%	73.74%	75th–89th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.99%	59.35%	65.44%^	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	59.26%	41.18%	45.24%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	94.10%	97.29%	98.57%	≥90th
Counseling for Nutrition—Total	97.18%	95.57%	96.18%	≥90th
Counseling for Physical Activity—Total	97.18%	95.57%	96.18%	≥90th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	96.58%	96.37%	94.20%	≥90th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	87.43%	87.44%	97.22%^	75th–89th
Ages 25 Months to 6 Years	79.56%	75.76%	83.25%^	10th–24th
Ages 7 to 11 Years	87.93%	86.56%	86.81%	10th–24th
Ages 12 to 19 Years	87.81%	88.45%	88.26%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	48.46%	41.43%	45.51%	10th–24th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.27%	0.17%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	45.16%	50th–74th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	98.91%	99.01%	96.94%	≥90th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	46.67%	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	23.33%	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	93.33%	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*ED Visits**	2.98	11.54	18.86	≥90th
Outpatient Visits[1]	179.23	151.08	133.57	<10th
Inpatient Utilization—General Hospital/Acute Care[1]				
Discharges per 1,000 Member Months (Total Inpatient)	0.64	0.62	0.49	<10th
Average Length of Stay (Total Inpatient)	3.35	3.51	3.67	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.49	0.46	0.40	<10th
Average Length of Stay (Medicine)	3.04	3.34	2.29	<10th
Discharges per 1,000 Member Months (Surgery)	0.15	0.12	0.08	<10th
Average Length of Stay (Surgery)	4.36†	4.24†	10.50†	<10th
Discharges per 1,000 Member Months (Maternity)	0.00	0.07	0.01	<10th
Average Length of Stay (Maternity)	NA	3.20†	3.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.28	0.26	0.19	≥90th
Average Days Supplied per Antibiotic Script	12.32	12.15	12.47	<10th
Average Scripts PMPY for Antibiotics of Concern	0.08	0.05	0.05	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.27%	19.57%	24.21%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

Kaiser: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for Kaiser:

- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *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*
- *Appropriate Testing for Children With Pharyngitis*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

For HEDIS 2019, Kaiser demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for eight of 11 (72.7 percent) measure rates and exceeding the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* indicator. Additionally, the MCO continued to demonstrate the appropriate management of members with respiratory infections and ensuring young women are not being screened unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for Kaiser:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

Kaiser demonstrated opportunities to improve the access to appropriate providers and services for members 2 years of age and older, as evidenced by the following measure rates falling below the 50th percentile: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Adolescent Well-Care*

Visits; *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*; and *Chlamydia Screening in Women—Ages 16 to 20 Years*. The MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or the need for improved community outreach and education) and implement strategies to improve the preventive care for these members.

Validation of Performance Improvement Projects

Table 3-23 presents the FY 2018–2019 validation findings for Kaiser's PIP.

Table 3-23—Validation Findings for the *Improving CHP+ Adolescent Well-Visit Adherence* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members aged 15–18 years attributed to Aurora Centrepoint Medical Office Building.
SMART Aim Statement	By June 30, 2020, increase the percentage of individuals with a well visit in the previous 12 months among continuously-enrolled CHP+ members aged 15–18 years who are linked to the Aurora Centrepoint Medical Office Building from 34.3% to 47.3%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	Percentage of Child Health Plan Plus members linked to Kaiser Permanente's Aurora Centrepoint Medical Offices and ages 15 through 18 as of the last day of the 12th month of the measurement year with at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the 12-month rolling measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Kaiser Permanente's Common Membership System and electronic medical records. • **Methodology:** Monthly data collection based on a rolling 12-month measurement period.

Kaiser: Strengths

Kaiser selected a PIP topic focused on increasing the rate of well-check visits among members 15 through 18 years of age. The CHP+ MCO passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that Kaiser designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. Kaiser has progressed to Module 3, where the CHP+ MCO will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, Kaiser will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As Kaiser continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

CAHPS Surveys

Findings

Table 3-24 shows the results achieved by Kaiser for FY 2016–2017 through FY 2018–2019.

Table 3-24—Question Summary Rates and Global Proportions for Kaiser

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	88.0%	84.5%	85.5%
Getting Care Quickly	92.0%	88.8%	90.8%
How Well Doctors Communicate	96.7%	95.7%	97.8%
Customer Service	85.1%	86.0%	86.5%
Shared Decision Making	80.4%+	88.2%+	84.9%+
Rating of Personal Doctor	72.9%	74.5%	78.1%
Rating of Specialist Seen Most Often	62.5%+	75.7%+	73.3%+
Rating of All Health Care	67.5%	68.1%	67.2%
Rating of Health Plan	61.0%	61.1%	60.9%

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.

Kaiser: Strengths

For Kaiser's CHP+ population, no measure rates increased substantially between FY 2017–2018 and FY 2018–2019.

Five of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Personal Doctor*

For Kaiser's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor* (5.2 percentage points)
- *Rating of Specialist Seen Most Often* (10.8 percentage points)

Three of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

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

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

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

Kaiser experienced no substantial rate decreases in FY 2018–2019 compared to the previous year: however, for the measure rates that showed slight decreases compared to the previous year, HSAG offers the following recommendations for Kaiser to consider based on population needs and MCO resources.

The *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG recommends that Kaiser consider the following:

- Continue to carefully monitor and evaluate the provider network, considering the total number of practitioners providing services to all payor sources, provider workloads, and available capacity for children and youth at various clinic locations within the network.
- Evaluate the effectiveness of current processes for telephonic or other technology-based communications with members that provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluate scheduling mechanisms related to CHP+ timely access to appointment standards, perhaps including assessment and training of schedulers to assess the urgency of an appointment request; and providing schedulers with CHP+ specific information to direct members to alternative sources of service when appropriate.
- Evaluate PCP to specialist referral patterns and consider expanding contracted specialist relationships.
- Ensure continued ongoing communication to remind members, providers, and call center staff members of timeliness access standards and where to access after-hours care.
- Consider further expanding use of walk-in clinics and services and provide members and families ongoing reminders of where to access walk-in care.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

Validation of Network Adequacy

Kaiser: Strengths

Kaiser's Provider Data Structure Questionnaire responses noted that Kaiser updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. DHMP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the Kaiser data system, these individual providers were not listed on provider network rosters. Kaiser reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

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

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although Kaiser noted using the self-reported provider specialty information to identify PCPs or PNC providers, Kaiser did not restrict these data indicators by degree or credential. Additionally, Kaiser's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map Kaiser's provider data to the Department's provider categories. Further, Kaiser reported that panel capacity information was not available in its provider data system, though Kaiser did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by Kaiser included no provider type values and offered limited specialty values for facility-level providers (e.g., hospitals).

As the first comprehensive review of Kaiser's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing Kaiser's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, Kaiser should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Rocky Mountain Health Plans (RMHP)

Assessment of Compliance With CHIP Managed Care Regulations

Table 3-25 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 2018–2019.

Table 3-25—Summary of RMHP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	8	2	0	0	80%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	18	18	15	3	0	0	83%
Totals	**68**	**68**	**62**	**6**	**0**	**0**	**91%**

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

Table 3-26 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

Table 3-26—Summary of RMHP Scores for the FY 2018–2019 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	91	91	0	9	100%
Recredentialing	90	86	86	0	4	100%
Totals	**190**	**177**	**177**	**0**	**13**	**100%**

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

RMHP: Strengths

RMHP's Care Coordination policy and procedure defined a comprehensive care management program to assist members with access to needed services. RMHP's care coordination program included coordinating with the members' providers, assisting in referrals to specialists and community-based organizations, providing complex care coordination for members receiving services from multiple providers and agencies, involving members and family members in treatment and service planning, and providing continuity of care for newly enrolled members. RMHP used available medical, behavioral, and social support needs data and information from intake screenings and comprehensive needs assessments to stratify all members into four tiers of need to determine potential care coordination interventions. RMHP provided evidence of well-integrated program staff members, as well as 10 additional integrated care coordination teams distributed regionwide, to provide care coordination services in local communities. Customer service staff members had procedures for conducting outreach welcome calls to all newly enrolled members to explain the benefits of the plan, assist members with selecting a PCP, conduct initial intake screenings, and identify member continuity of care needs. If intake screenings indicated that a member may have coordination or continuity of care needs, customer service staff members referred the member to care management staff members for follow-up and further assessment. RMHP care coordination staff members assumed the lead coordinator role for all members with complex needs and had policies and procedures for ensuring transitions of care between settings, coordinating with other health plans when applicable, and coordinating with community organizations and agencies. All documentation of member-specific care management information, including health needs assessments and service plans, was entered and maintained in the Essette care management software, which enabled secure sharing of care coordination files among designated health entities in the region. Provider service agreements and the provider manual outlined requirements for maintaining and sharing medical records with other providers in a HIPAA-compliant manner. RMHP's comprehensive care coordination program and integrated staff members and procedures ensured that all CHP+ members had access to care coordination services appropriate to their needs.

RMHP policies and procedures delineated the member rights and responsibilities and included methods for the distribution of these rights to members and providers. The CHP+ member booklet and RMHP website identified the full list of member rights. RMHP required, through its provider contracts, that providers take these member rights into account when furnishing services. RMHP had procedures for monitoring member calls to customer service to identify any issue of dissatisfaction that could be related to a rights issue. RMHP addressed advance directive information within its policies, the CHP+ benefits booklet, and the RMHP provider manual. RMHP policies, staff procedures, and mandatory in-service trainings addressed compliance with federal and State laws pertaining to member rights, including HIPAA privacy requirements.

RMHP's policies and procedures related to the initial credentialing and recredentialing of providers and organizations were well-organized, thorough, and compliant with NCQA credentialing and recredentialing standards and guidelines. Credentialing and recredentialing record reviews demonstrated that staff members were credentialing and recredentialing providers and health delivery organizations in a manner consistent with the written procedures and all NCQA-required standards. RMHP staff members described a process for monthly review of OIG and SAM queries. RMHP provided evidence

of a facility site evaluation tool and assessment survey to evaluate organizations that had not had a State site survey and were not currently accredited. RMHP delegated credentialing and recredentialing to several contracted organizations and provided audit reports demonstrating oversight of delegated providers. Delegation agreements described required credentialing activities, responsibilities, and reporting requirements, and delineated remedies should the delegate fall short of its obligations.

RMHP's Quality Improvement Program description, corporate QI work plan, and monthly committee meeting minutes demonstrated a multidisciplinary, multidepartmental comprehensive QAPI program. The program was supported by three primary oversight committees and included routine reporting, analysis of results, and planned interventions for quality improvement initiatives. Components of the Quality Improvement Program (QIP) included, but were not limited to, CHP+ PIPs, CHP+ HEDIS measures, and CAHPS data. The CHP+ PIP met the required design parameters. The annual QIP impact analysis included an assessment of quality improvement effectiveness within each major area of activity. RMHP staff members also described the Practice Transformation Program, which was designed to coach and assist providers in improving quality of care and performance within individual practices. RMHP adopted CPGs in compliance with requirements and had practice guidelines in place for CHP+ specific health conditions as required by the Department. RMHP distributed CPGs to providers and members through the RMHP website and staff members stated that select practice guidelines were distributed to individual practices through the Practice Transformation Program. RMHP's HIS documents outlined a highly integrated multi-component data system for collecting, processing, and reporting claims as well as clinical and operational information. RMHP collected information from providers in standardized formats. Claims data received from providers were verified for completeness and accuracy through three separate and increasingly detailed electronic editing applications, with additional manual review as necessary. RMHP's policies and procedures described the process for monthly claims submission to the Department in required formats.

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

HSAG identified no opportunities for improvement that resulted in required actions related to Standard VIII—Credentialing and Recredentialing.

Standard III—Coordination and Continuity of Care

While RMHP demonstrated having a variety of member communications intended to ensure that each member selects a PCP, RMHP did not have a routine mechanism to inform a CHP+ member of how to contact his or her designated PCP. While RMHP demonstrated mechanisms to conduct an initial intake screening of all newly enrolled CHP+ members, the intake screening implemented during the compliance review period did not include assessment for BH needs, functional problems, or other complex health needs, as required by the Department. RMHP was required to:

- Implement a mechanism to inform each member how to contact his or her PCP for ongoing coordination of healthcare services.

- Implement an expanded intake assessment that addresses all required components of the health screening defined by the Department.

Standard IV—Member Rights and Protections

While RMHP provided education to providers and adult members regarding advance directives, RMHP did not have provisions for educating the community at large regarding advance directives. RMHP was required to:

- Develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard X—Quality Assessment and Performance Improvement

RMHP did not demonstrate that it reviewed and analyzed utilization measures to detect over- or underutilization as a component of the QAPI program. In addition, while the QAPI program description addressed mechanisms in place to manage the care needed by individual members with SHCN, the intent of the care management activities was not to assess the quality of care provided to CHP+ members with SHCN. While RMHP verbally described a process for ensuring UM decisions were consistent with CPGs, written procedures and processes did not articulate accountabilities for ensuring consistency of UM guidelines with CPGs, nor was a process outlined to ensure that member education materials or other operational activities were consistent with applicable CPGs. RMHP was required to:

- Define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services by CHP+ members.
- Develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care furnished to CHP+ members with SHCN.
- Enhance internal procedures and defined accountabilities to ensure that decisions for UM, member education, coverage of services, and other areas to which CPGs apply are consistent with adopted guidelines.

RMHP: Trended Performance for Compliance With Regulations

Table 3-27 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 3-27—Compliance With Regulations Trended Performance for RMHP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	97%
Standard II—Access and Availability (2013–2014, 2016–2017)	86%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**100%**	**80%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**80%**	**88%**
Standard V—Member Information (2014–2015, 2017–2018)	52%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	77%	82%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	94%	93%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*	**100%**	**100%**
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*	**100%**	**83%**

**Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that RMHP improved performance in five of the 10 standards, with the greatest increase (48 percentage points) in Standard V—Member Information and moderate increases (12 to 14 percentage points) in Standard I—Coverage and Authorization and Standard II—Access and Availability. RMHP demonstrated a slight increase (less than 10 percentage points) in performance in Standard IV—Member Rights and Protections and Standard VI—Grievance and Appeal System. RMHP experienced declines of at or near 20 percentage points in performance for Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement. In two standard areas, Standard VII—Provider Participation and Program Integrity and Standard VIII—Credentialing and Recredentialing, RMHP maintained consistent performance above 90 percent. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as "NA" to CHP+ MCOs in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

Validation of Performance Measures

Compliance With IS Standards

According to RMHP's 2019 HEDIS Compliance Audit Report, RMHP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted RMHP's HEDIS performance measure reporting.

Performance Measure Results

Table 3-28 shows the performance measure results for RMHP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

Table 3-28—Performance Measure Results for RMHP

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	58.27%	64.80%	57.08%	<10th
Combination 3	55.91%	62.40%	57.08%	<10th
Combination 4	54.33%	60.40%	54.42%	<10th
Combination 5	51.57%	54.40%	54.87%	10th–24th
Combination 6	43.31%	41.20%	41.15%	50th–74th
Combination 7	50.39%	53.20%	52.21%	10th–24th
Combination 8	42.13%	41.20%	39.38%	25th–49th
Combination 9	40.16%	36.40%	39.82%	50th–74th
Combination 10	39.37%	36.40%	38.05%	50th–74th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	49.61%	60.87%	57.67%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	—	13.71%	18.33%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	3.00%	5.00%	0.00%^	≥90th
Six or More Visits	23.00%	29.00%	**15.79%^^**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.66%	68.75%	67.68%	25th–49th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.69%	47.07%	49.19%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	4.44%	4.38%	4.83%	<10th
Counseling for Nutrition—Total	19.04%	21.52%	23.00%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Counseling for Physical Activity—Total	1.29%	3.51%	5.50%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	78.26%	80.27%	77.64%	25th–49th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	91.26%	93.48%	94.68%	25th–49th
Ages 25 Months to 6 Years	82.13%	83.49%	82.81%	10th–24th
Ages 7 to 11 Years	86.72%	86.90%	88.00%	25th–49th
Ages 12 to 19 Years	87.34%	86.82%	87.04%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	23.31%	31.93%	33.57%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	NA	47.06%	53.33%	75th–89th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	95.41%	95.80%	93.68%	50th–74th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*ED Visits**	18.26	18.26	18.38	≥90th
Outpatient Visits[1]	212.07	218.41	211.60	<10th
Inpatient Utilization—General Hospital/Acute Care[1]				
Discharges per 1,000 Member Months (Total Inpatient)	0.73	0.89	0.75	<10th
Average Length of Stay (Total Inpatient)	3.01	4.11	4.37	50th–74th
Discharges per 1,000 Member Months (Medicine)	0.45	0.59	0.49	<10th
Average Length of Stay (Medicine)	2.57	3.29	3.27	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.28	0.21	<10th
Average Length of Stay (Surgery)	3.71	5.91	7.46†	<10th
Discharges per 1,000 Member Months (Maternity)	0.02	0.03	0.10	<10th
Average Length of Stay (Maternity)	4.00†	2.50†	2.33†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.40	0.40	0.39	≥90th
Average Days Supplied per Antibiotic Script	10.49	10.18	10.20	<10th
Average Scripts PMPY for Antibiotics of Concern	0.15	0.14	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	38.64%	35.07%	35.98%	75th–89th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.
— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.
Rated shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

RMHP: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for RMHP:

- *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

For HEDIS 2019, RMHP demonstrated strong performance ensuring children received at least one well-child visit by exceeding the 90th percentile for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator. Additionally, the MCO continued to demonstrate strength ensuring that young women were not screened unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for RMHP:

- *Childhood Immunization Status—Combinations 2–5* and *7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

RMHP's performance demonstrated opportunities to improve access to care and services for children and adolescents, with all but one rate for the well-child/well-care visits measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits*) and all rates for the *Children and Adolescents' Access to Primary Care Practitioners* measure below the 50th percentile. Further, rates for *Immunizations for Adolescents*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, *Chlamydia Screening in Women*, and eight of 11 (72.7 percent) *Childhood Immunization Status* indicators were below the 50th percentile for HEDIS 2019. The MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source

challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.[3-18]

Validation of Performance Improvement Projects

Table 3-29 presents the FY 2018–2019 validation findings for RMHP's PIP.

Table 3-29—Validation Findings for the *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Mountain Family Health Center.
SMART Aim Statement	By 6/30/2020, increase the percentage of well-child visits among CHP+ Members at Mountain Family Health Center 15 through 18 years of age, from 42.39% to 53.26%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 15 through 18 years of age attributed to Mountain Family Health Center during the rolling 12-month measurement period who received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

RMHP: Strengths

RMHP selected a PIP topic focused on increasing the rate of well-child visits among members 15 to 18 years of age. The CHP+ MCO passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that RMHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. RMHP has progressed to Module 3, where the CHP+ MCO will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, RMHP will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test

[3-18] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Jul 16, 2019.

and refine interventions to achieve the goal for the project. As RMHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- The intended effect of the intervention should be determined before testing begins to ensure a sound data collection plan for the intervention evaluation. Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

CAHPS Surveys

Findings

Table 3-30 shows the results achieved by RMHP for FY 2016–2017 through FY 2018–2019.

Table 3-30—Question Summary Rates and Global Proportions for RMHP

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
Getting Needed Care	88.2%	88.4%	90.1%
Getting Care Quickly	92.5%	91.8%	93.3%
How Well Doctors Communicate	97.3%	97.9%	97.1%
Customer Service	86.2%+	83.9%	87.9%
Shared Decision Making	76.2%+	84.2%+	84.8%+
Rating of Personal Doctor	77.6%	72.8%	71.2%
Rating of Specialist Seen Most Often	77.5%+	80.5%+	82.9%+
Rating of All Health Care	66.6%	67.2%	67.7%
Rating of Health Plan	60.6%	63.2%	68.3%

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.

RMHP: Strengths

For RMHP's CHP+ population, one measure rate increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Health Plan* (5.1 percentage points)

Six of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*

For RMHP's CHP+ population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Shared Decision Making* (8.6 percentage points)
- *Rating of Specialist Seen Most Often* (5.4 percentage points)
- *Rating of Health Plan* (7.7 percentage points)

Four of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Rating of All Health Care*

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

For RMHP's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Two of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

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

For RMHP's CHP+ population, one measure rate decreased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor* (6.4 percentage points)

One of the measures showed a slight rate decrease between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*

RMHP experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, two measurement rates showed slight decreases. The *How Well Doctors Communicate* and the *Rating of Personal Doctor* measures could be impacted by many variables, including members' access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG offers the following for RMHP to consider based on population needs and MCO resources:

- Expand the frequency and diversity of training by coordinating cultural competency trainings with community organizations.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

Validation of Network Adequacy

RMHP: Strengths

RMHP's Provider Data Structure Questionnaire responses noted that RMHP validated providers' type and specialty information against the following public data verification resources: NPPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. RMHP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the RMHP data system, these individual providers were not listed on provider network rosters. RMHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

RMHP reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties. RMHP also reported using a status

confirmation process to identify and verify provider directory notations for providers with a PCP-like specialty who did not wish to serve as a PCP. RMHP reported conducting monthly outreach to PCPs to verify demographic, location, and panel capacity information.

RMHP identified PNC providers as individuals with an OB/GYN or nurse midwifery specialty, but also included selected family medicine practitioners who offer OB/GYN services.

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

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although RMHP consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, RMHP did not restrict these data indicators by degree or credential. Additionally, RMHP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map RMHP's provider data to the Department's provider categories. RMHP's data submission reflected physician-level taxonomy codes for NPs' provider records; because these NPs had no NP taxonomy codes, HSAG was unable to assign these providers to applicable PCA categories. Finally, provider data submitted by RMHP included no records for substance abuse treatment facilities.

As the first comprehensive review of RMHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing RMHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, RMHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Delta Dental of Colorado (Delta Dental)

Assessment of Compliance With CHIP Managed Care Regulations

Due to a contract end date of July 1, 2019, FY 2018–2019 was both the initial and final year for review of Delta Dental's compliance with CHP+ managed care requirements; therefore, the compliance review was conducted in a readiness format, which included abbreviated versions of nine different standards. HSAG found that Delta Dental was compliant with 15 of 27 total requirements and that 12 of 27 requirements were either partially met or not met. HSAG provided recommendations for improvement for those elements that were either partially met or not met.

Delta Dental Summary of Compliance

- Delta Dental developed a website that includes CHP+ program information, a downloadable summary of children's dental benefits, a secure member portal, printable copies of the CHP+ Evidence of Coverage benefits booklet and provider directory, and a link to the Health First Colorado CHP+ website portal.
- Delta Dental made oral interpretation services in all languages available to its providers and members.
- Delta Dental's website provider directory listed provider name, group affiliation, address, telephone number, specialty, and stated that all providers accepted new members.
- Delta Dental used multiple methods to communicate important information to providers, including provider contracts and two dental provider handbooks.
- Delta Dental had recently implemented GeoAccess mapping specific to the providers serving the CHP+ member population and a process to ensure that providers are enrolled with the State as CHP+ providers.
- Delta Dental's policies and processes for initial and ongoing provider credentialing were compliant with State and federal requirements.
- Delta Dental covered dental services needed to evaluate and stabilize an emergency dental condition, regardless of whether or not the services were provided in network.
- Within the written delegation agreements, Delta Dental included contract language specifying the delegated activities or obligations and related reporting responsibilities and assigned a staff member responsible for each delegation agreement.
- Delta Dental's CHP+ compliance officer described the compliance program in detail. Employees were trained on compliance issues and fraud, waste, and abuse (FWA). Delta Dental routinely monitored provider claims for potential FWA, with follow-up as indicated, and had processes for collecting and reporting overpayments to the Department.
- Delta Dental had processes to ensure that member care was coordinated as needed between settings of care and among various provider types, particularly for members with complex cases.

- Delta Dental participated in required PIPs and also used claims data to conduct an analysis of overutilization.
- Delta Dental demonstrated having a fully integrated HIS that included utilization data, grievances and appeals, membership enrollment history, provider demographic files, and reporting functions. The dental plan's claims system was able to collect all necessary data elements, verified for accuracy, to enable mechanized claims processing and to submit reports to the Department in required formats.

Delta Dental Summary of Opportunities for Improvement

- Delta Dental did not provide notification on its website of the availability of member materials in large print or alternative formats, and critical written materials failed to include taglines in non-English languages.
- Delta Dental's website included a significant number of readability and contrast errors when tested with the WAVE accessibility tool to determine compliance with Americans with Disabilities Act requirements.
- Delta Dental did not include all required elements within the paper or electronic form of the provider directory.
- Delta Dental had not yet adopted dental practice guidelines and did not communicate details about the grievance and appeal system to providers.
- Delta Dental's processes for authorization of initial and ongoing dental services did not align with Medicaid managed care regulations, including defined authorization time frames and procedures, notice of adverse benefit determination letters being sent to the member, and member appeal rights.
- Delta Dental's Complaint Handling policy was not compliant with all federal and State regulations for disposition of a grievance, including time frames for resolving a grievance and providing the member with written acknowledgement of a grievance.
- Delta Dental's CHP+ appeals procedures were not in alignment with all Medicaid managed care regulations, including timelines for processing appeals. Procedures also defined a "reconsideration" process that allowed for a second level of appeal (not permitted per Medicaid managed care regulations).
- Delta Dental did not include all required elements within the delegation subcontracts, including: provision for revocation or remedies; agreement to comply with applicable laws and regulations; and State, CMS, or Department of Health and Human Services inspector general right-to-audit requirements. In addition, Delta Dental did not have policies or procedures governing the oversight and monitoring of the delegates' performance.
- Delta Dental did not incorporate directors, officers, partners, employees, subcontractors, or owners within its monthly search of federal exclusion lists.
- Delta Dental did not have a method to ensure that each member had a provider or provider group as an ongoing source of primary dental care or responsible for coordinating the member's dental services.
- Delta Dental did not have a comprehensive QAPI program that incorporated all required components.

Validation of Performance Measures

An independent review was performed on Delta Dental's claims and enrollment data from July 2018 through April 2019; however, this review was not a HEDIS compliance audit, therefore, rates submitted by Delta Dental were not validated rates.

Performance Measure Results

Table 3-31 shows the performance measure results for Delta Dental. Of note, the Department provided the number of members eligible to receive dental services through the CHP+ dental PAHP and Delta Dental provided the count of members who had at least one dental visit during FY 2018–2019. Subsequently, HSAG calculated the rate for the *Annual Dental Visit* measure.

Table 3-31—Performance Measure Results for Delta Dental

Performance Measure	HEDIS 2019 Rate	Percentile Ranking
Annual Dental Visit[1]		
Total	37.09%	10th–24th

[1] *The age range for this measure rate was modified to less than 1 year old to age 19 during the measurement period (i.e., July 2018–June 2019). Therefore, the reader should exercise caution when comparing the rate to benchmarks generated for ages 2 to 20 years during calendar year 2017.*

The *Annual Dental Visit—Total* rate fell below the 25th percentile for HEDIS 2019, indicating opportunities to improve the number of preventive dental visits for members.

Validation of Performance Improvement Projects

Table 3-32 displays the FY 2018–2019 validation findings Delta Dental's PIP.

Table 3-32—Validation Findings for the *Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 3 through 5 years of age who reside in the Greeley area.
SMART Aim Statement	By June 30, 2020, increase the percentage of CHP+ members who reside in the Greeley area who utilized any service among the 3–5-year-old age group from 35.96% to 38%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 3 through 5 years of age who reside in the Greeley area and utilized any dental service during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

Delta Dental: Strengths

Delta Dental selected a PIP topic focused on increasing dental service utilization among members 3 through 5 years of age. The MCO passed Module 1 and Module 2 and achieved all validation criteria for the PIP. The validation findings suggest that the MCO developed a methodologically sound project design and established a PIP team with appropriate membership to achieve the goal for improvement.

Delta Dental: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Completion of Module 1 and Module 2 concluded Delta Dental's PIP submissions for validation as the MCO's contract with the Department to provide dental services for CHP+ members ended June 30, 2019. After the MCO completed and passed Module 1 and Module 2 in April 2019, the Department and HSAG agreed that Delta Dental had fulfilled the FY 2018–2019 PIP validation requirements. The remainder of the FY would not have allowed time for the MCO to complete and submit subsequent modules of the PIP for validation. HSAG recommends the following strategies for Delta Dental, which can be applied to general quality improvement efforts beyond the rapid-cycle PIP:

- When planning a test of change or intervention, think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- Determine the best method for identifying the intended effect of an intervention prior to testing it. The intended effect of the intervention should be known beforehand to help determine a sound data collection plan for the intervention evaluation measure(s).
- When testing a new intervention, make a prediction of expected results in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. Discussing predicted results will help keep the theory for improvement at the forefront for all involved in the project.
- Key driver diagrams should be developed when an improvement project is initiated and should be updated regularly to incorporate knowledge gained and lessons learned through PDSA cycles.

Validation of Network Adequacy

Delta Dental's Provider Data Structure Questionnaire responses noted that Delta Dental validated providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP applications. Delta Dental reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

Delta Dental's provider data extract for the study contained key limitations, suggesting the data did not accurately reflect Delta Dental's complete provider network. For example, data included no attribute values for provider groups or practices, indicating that group-level provider records, if available, may be identified using other network database elements. Delta Dental also noted that it does not permit services to be offered by out-of-network providers (i.e., using single case agreements or similar approaches).

As the first comprehensive review of Delta Dental's provider network, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing compliance with network adequacy standards for the CHP+ dental PAHP.

As Delta Dental's contract with the Department ended June 30, 2019, HSAG provides no recommendations for Delta Dental in this report.

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

Assessment of Compliance With CHIP Managed Care Regulations

Table 4-1—Statewide Results for CHP+ Managed Care Standards

Description of Standard	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2016–2017)	94%	94%	91%	94%	97%	94%
Standard II—Access and Availability (2016–2017)	100%	92%	79%	93%	100%	93%
Standard III—Coordination and Continuity of Care (2018–2019)	**100%**	**60%**	**78%**	**80%**	**80%**	**80%**
Standard IV—Member Rights and Protections (2018–2019)	**88%**	**100%**	**88%**	**88%**	**88%**	**90%**
Standard V—Member Information (2017–2018)	100%	83%	92%	100%	100%	95%
Standard VI—Grievance and Appeal System (2017–2018)	95%	91%	82%	68%	82%	84%
Standard VII—Provider Participation and Program Integrity (2017–2018)	100%	79%	93%	87%	93%	90%
Standard VIII—Credentialing and Recredentialing (2018–2019)	**100%**	**100%**	**86%**	**100%**	**100%**	**97%**
Standard IX—Subcontracts and Delegation (2017–2018)	NA	NA	NA	NA	NA	NA
Standard X—Quality Assessment and Performance Improvement (2018–2019)	**89%**	**89%**	**83%**	**89%**	**83%**	**87%**

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.

Table 4-2—Statewide Results for CHP+ Managed Care Record Reviews

Record Reviews	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
Appeals (2017–2018)	93%	83%	100%	NA	83%	90%
Credentialing (2018–2019)	**100%**	**100%**	**97%**	**100%**	**100%**	**99%**
Denials (2016–2017)	100%	0%	98%	100%	97%	90%
Grievances (2017–2018)	100%	NA	100%	75%	85%	89%
Recredentialing (2018–2019)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.
NA: DHMP reported no CHP+ member grievances and Kaiser reported no CHP+ member appeals during the FY 2017–2018 review period.

Statewide Conclusions and Strengths Related to Compliance With Regulations

For the four standards reviewed in FY 2018–2019, the CHP+ MCOs demonstrated compliance in many areas. All or most (three or more) CHP+ MCOs demonstrated the following strengths:

- Maintained robust and comprehensive policies, procedures, and program descriptions for Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and QAPI.
- Maintained processes for comprehensive care management to assist CHP+ members with access to needed services, including assisting with referrals, coordinating with multiple providers and agencies for members with complex care needs, and coordinating services with community organizations, as indicated.
- Had processes to ensure continuity of care for newly enrolled CHP+ members.
- Had processes for allowing CHP+ members direct access to specialists in or out of network.
- Had procedures for conducting intake screenings and comprehensive needs assessments and for developing related care coordination service plans for CHP+ members.
- Had care coordination processes for ensuring transition of care between multiple settings of care or between health plans.
- Had multi-disciplinary teams of care coordinators distributed throughout the service area or delivery system.
- Maintained care coordination documentation systems to enable collecting and secure sharing of members' care coordination information.
- Maintained policies and systems for compliance with HIPAA privacy regulations for sharing member records and ensuring confidentiality of CHP+ member information.
- Maintained policies and provider and member communications outlining required member rights.
- Provided staff member and provider trainings related to CHP+ member rights.
- Demonstrated processes for monitoring member customer service calls to identify and address any issues related to member rights.
- Maintained policies and provider and member communications addressing the required components and provisions for advance directives.
- Maintained credentialing and recredentialing policies and procedures compliant with NCQA requirements and demonstrated implementation of those procedures consistent with NCQA standards and guidelines.
- Delegated provider credentialing and recredentialing activities to large provider organizations and demonstrated oversight of delegate credentialing and recredentialing performance.
- Demonstrated conducting monthly screening of all providers against federal exclusion databases.
- Maintained comprehensive QAPI programs that included CHP+ PIPs, HEDIS measures, CAHPS surveys, and various other quality oversight measures and analysis.
- Had processes to conduct annual evaluation of the effectiveness of QAPI activities.

- Had processes to adopt and distribute to providers and members CPGs and had adopted clinical guidelines for all CHP+ health conditions required by the Department.
- Demonstrated having integrated multi-component HISs for collecting, processing, and reporting of claims, clinical, and operational information.
- Had processes for ensuring claims data received from providers were verified for accuracy and completeness.
- Had processes for submitting claims data monthly to the Department in required formats.

Statewide Conclusions and Recommendations Related to Compliance With Regulations

For CHP+ MCOs, the most common required actions (involving three or more MCOs) were the following:

- Ensure that the intake screening of each CHP+ member's needs includes all Department-required categories of assessment—mental health, high-risk health problems, functional problems, language or comprehension barriers, other complex health problems.
- Implement mechanisms within the QAPI program for review and analysis of data to detect over- or underutilization of services.
- Develop and implement mechanisms within the QAPI program to assess the quality and appropriateness of care furnished to members with SHCN.

Validation of Performance Measures

In Table 4-3, plan-specific and statewide weighted averages are presented for the CHP+ MCOs for HEDIS 2019. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the MCOs' eligible populations. For the MCOs with rates reported as *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate.

Table 4-3—MCO and Statewide Results

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Pediatric Care						
Childhood Immunization Status						
Combination 2	71.58%	67.46%	4.76%	69.46%	57.08%	66.78%
Combination 3	69.58%	65.87%	4.76%	67.36%	57.08%	65.16%
Combination 4	66.86%	65.87%	4.76%	66.95%	54.42%	63.13%
Combination 5	63.21%	57.94%	4.76%	62.76%	54.87%	59.76%
Combination 6	49.53%	46.03%	0.00%	41.84%	41.15%	45.31%

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Combination 7	61.32%	57.94%	4.76%	62.34%	52.21%	58.20%
Combination 8	48.23%	46.03%	0.00%	41.84%	39.38%	44.29%
Combination 9	45.64%	41.27%	0.00%	40.59%	39.82%	42.27%
Combination 10	44.58%	41.27%	0.00%	40.59%	38.05%	41.39%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	76.30%	82.24%	26.32%	82.84%	57.67%	73.33%
Combination 2 (Meningococcal, Tdap, HPV)	38.90%	55.92%	12.28%	56.44%	18.33%	39.02%
Well-Child Visits in the First 15 Months of Life						
*Zero Visits**	6.36%	15.15%	NA	2.02%	0.00%	5.06%
Six or More Visits	47.27%	63.64%	NA	73.74%	15.79%	48.28%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.50%	64.74%	55.62%	65.44%	67.68%	67.34%
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	49.87%	45.30%	37.65%	45.24%	49.19%	48.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	9.27%	21.80%	9.70%	98.57%	4.83%	22.71%
Counseling for Nutrition—Total	5.11%	7.93%	4.65%	96.18%	23.00%	21.46%
Counseling for Physical Activity—Total	3.14%	6.65%	6.26%	96.18%	5.50%	17.58%
Appropriate Testing for Children With Pharyngitis						
Appropriate Testing for Children With Pharyngitis	84.60%	83.33%	81.16%	94.20%	77.64%	84.99%
Access to Care						
Prenatal and Postpartum Care^						
Timeliness of Prenatal Care	—	—	—	—	—	55.13%
Postpartum Care	—	—	—	—	—	45.01%
Children and Adolescents' Access to Primary Care Practitioners						
Ages 12 to 24 Months	90.30%	90.36%	NA	97.22%	94.68%	92.33%
Ages 25 Months to 6 Years	84.52%	73.58%	71.90%	83.25%	82.81%	82.93%
Ages 7 to 11 Years	87.98%	86.93%	87.18%	86.81%	88.00%	87.66%
Ages 12 to 19 Years	87.78%	82.04%	86.43%	88.26%	87.04%	87.14%
Preventive Screening						
Chlamydia Screening in Women						
Ages 16 to 20 Years	32.27%	47.22%	NA	45.51%	33.57%	36.52%

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Non-Recommended Cervical Cancer Screening in Adolescent Females*						
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.08%	0.00%	0.00%	0.00%	0.00%	0.04%
Mental/Behavioral Health						
Antidepressant Medication Management						
Effective Acute Phase Treatment	NA	NA	NA	NA	NA	55.00%
Effective Continuation Phase Treatment	NA	NA	NA	NA	NA	37.50%
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	0.00%	NA	NA	45.16%	53.33%	15.21%
Continuation and Maintenance Phase	NA	NA	NA	NA	NA	20.00%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
Total	30.49%	NA	NA	NA	NA	38.98%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*						
Total	3.23%	NA	NA	NA	NA	4.04%
Respiratory Conditions						
Appropriate Treatment for Children With Upper Respiratory Infection						
Appropriate Treatment for Children With Upper Respiratory Infection	93.25%	100.00%	92.63%	96.94%	93.68%	94.09%
Medication Management for People With Asthma						
Medication Compliance 50%—Ages 5 to 11 Years	58.41%	NA	NA	NA	NA	59.75%
Medication Compliance 50%—Ages 12 to 18 Years	50.00%	NA	NA	NA	NA	51.64%
Medication Compliance 75%—Ages 5 to 11 Years	36.28%	NA	NA	NA	NA	33.96%
Medication Compliance 75%—Ages 12 to 18 Years	23.33%	NA	NA	NA	NA	27.05%
Asthma Medication Ratio						
Ages 5 to 11 Years	83.19%	NA	NA	NA	NA	82.63%
Ages 12 to 18 Years	75.79%	NA	NA	NA	NA	71.32%
Use of Services†						
Ambulatory Care (Per 1,000 Member Months)						
*ED Visits**	26.90	21.49	17.33	18.86	18.38	23.83
Outpatient Visits	218.12	135.56	166.81	133.57	211.60	195.91
Inpatient Utilization—General Hospital/Acute Care						
Discharges per 1,000 Member Months (Total Inpatient)	1.03	0.82	0.37	0.49	0.75	0.88
Average Length of Stay (Total Inpatient)	3.43	3.07	2.33†	3.67	4.37	3.51

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Discharges per 1,000 Member Months (Medicine)	0.74	0.60	0.21	0.40	0.49	0.63
Average Length of Stay (Medicine)	2.97	2.59	2.00†	2.29	3.27	2.89
Discharges per 1,000 Member Months (Surgery)	0.25	0.17	0.17	0.08	0.21	0.21
Average Length of Stay (Surgery)	4.90	5.07†	1.50†	10.50†	7.46†	5.50
Discharges per 1,000 Member Months (Maternity)	0.09	0.09	0.00	0.01	0.10	0.07
Average Length of Stay (Maternity)	2.58†	2.00†	NA	3.00†	2.33†	2.49
Antibiotic Utilization*						
Average Scripts PMPY for Antibiotics	0.35	0.14	12.00	0.19	0.39	0.33
Average Days Supplied per Antibiotic Script	10.87	11.28	99.95	12.47	10.20	16.86
Average Scripts PMPY for Antibiotics of Concern	0.12	0.03	2.32	0.05	0.14	0.11
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.71%	24.04%	19.35%	24.21%	35.98%	31.91%

** For this indicator, a lower rate indicates better performance.*
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
^ The SMCN is the only CHP+ MCO required to report the Prenatal and Postpartum Care measure.
† For measures in the Use of Services domain, higher or lower rates did not necessarily denote better or poorer performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Statewide Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*

At the statewide level, vaccinations for children and adolescents—driven by high influenza, rotavirus, and HPV vaccination rates—were identified as a statewide strength for HEDIS 2019. Additionally, the State continued to demonstrate strength by not screening young women unnecessarily for cervical cancer and by ensuring providers appropriately treat members with respiratory infections.

Statewide Opportunities for Improvement and Recommendations Related to Health Plan Performance Measure Results

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2*, *3*, and *4*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, and *Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Statewide performance for HEDIS 2019 demonstrated opportunities to improve the access to preventive care and services for members, including chlamydia screening and follow-up care for members prescribed ADHD medications.

Validation of Performance Improvement Projects

Table 4-4 shows the FY 2018–2019 statewide PIP results for the CHP+ health plans.

Table 4-4—FY 2018–2019 PIP Results for the CHP+ Health Plans

Health Plan	PIP Topic	Module Status	Validation Status
COA	*Well-Child Visits for Members 10–14 Years of Age*	Completed Module 1 and Module 2	NA*
DHMP	*Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age*	Completed Module 1 and Module 2	NA*
FHP	*Well-Child Visits in the 6th Through 14th Years of Life*	Completed Module 1 and Module 2	NA*
Kaiser	*Improving CHP+ Adolescent Well-Visit Adherence*	Completed Module 1 and Module 2	NA*
RMHP	*Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	Completed Module 1 and Module 2	NA*
Delta Dental	*Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year*	Completed Module 1 and Module 2	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.*

During FY 2018–2019, the CHP+ health plans initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs addressed the following topic areas:

- Well-child visits
- Adolescent well-care visits
- Dental service utilization

The PIPs run on an 18-month schedule and will continue into the next FY. The PIPs will be evaluated on outcomes and receive a final validation status after the CHP+ health plans complete all five modules of the rapid-cycle PIP process and submit final documentation for validation. One exception to this progression is the Delta Dental PIP. Delta Dental's PIP will not progress beyond Module 1 and Module 2 because the PAHP's contract with the Department to deliver dental services for CHP+ members ended at the end of FY 2018–2019.

During the FY 2018–2019 validation cycle, the CHP+ health plans received training and technical assistance on the rapid-cycle PIP process and developed the foundation of the projects in the first two modules of the process. The CHP+ health plans submitted documentation on Module 1 and Module 2

for a total of six PIPs. HSAG provided feedback to the CHP+ health plans on the initial submissions and the CHP+ health plans revised the module documentation and resubmitted Module 1 and Module 2 until all criteria were achieved. The CHP+ health plans passed Module 1 and Module 2, achieving all validation criteria for the first two modules for all six PIPs.

Statewide Conclusions and Recommendations for PIPs

The FY 2018–2019 validation findings for all six PIPs suggested that all CHP+ health plans designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. The CHP+ health plans used data to identify a narrowed focus for each project, established PIP teams to include necessary internal and external partners, defined a goal for improvement, and designed a measure and data collection plan to evaluate progress toward achieving the goal. In the next FY, the CHP+ health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. As the CHP+ health plans continue working on the PIPs, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

CAHPS Surveys

Statewide Results for CAHPS

The statewide averages presented in Table 4-5 are derived from the combined results of the five CHP+ MCOs. Table 4-5 shows the FY 2018–2019 plan-level and statewide average results for each CAHPS measure.

Table 4-5—Statewide Comparison of Question Summary Rates and Global Proportions

Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
Getting Needed Care	87.7%	79.7%	90.1%+	85.5%	90.1%	87.1%
Getting Care Quickly	90.5%	85.0%	91.0%+	90.8%	93.3%	90.5%
How Well Doctors Communicate	94.8%	94.4%	92.9%	97.8%	97.1%	95.4%
Customer Service	81.9%	87.8%	84.0%+	86.5%	87.9%	84.0%
Shared Decision Making	79.6%+	72.8%+	80.4%+	84.9%+	84.8%+	80.4%
Rating of Personal Doctor	78.0%	75.7%	71.0%	78.1%	71.2%	76.6%
Rating of Specialist Seen Most Often	77.1%+	85.3%+	71.1%+	73.3%+	82.9%+	77.9%
Rating of All Health Care	67.7%	69.2%	50.6%	67.2%	67.7%	67.1%
Rating of Health Plan	69.3%	65.4%	55.2%	60.9%	68.3%	67.1%

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

Statewide Conclusions and Recommendations for CAHPS

Each member experience measure displayed substantial or slight increases of member and family perceptions regarding quality of care and services between FY 2017–2018 and FY 2018–2019 in three or more MCOs except *How Well Doctors Communicate* and *Rating of All Health Care*. *Rating of Health Plan* increased in four of the five MCOs, and in three of those substantially: COA, FHP, and RMHP. Also, four of five plans' ratings showed improvements in *Getting Needed Care* and *Customer Service*. *Rating of Personal Doctor* increased in three of the five CHP+ MCOs, and in one of three MCOs substantially, FHP. Also, three of five MCOs' ratings showed improvements in *Getting Care Quickly*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*. *How Well Doctors Communicate* and *Rating of All Health Care* increased in only one of the five CHP+ MCOs. Only one measure, *Rating of Specialist Seen Most Often*, had two CHP+ MCO rates substantially higher than the statewide average.

One of the five CHP+ MCOs, COA, had no rates substantially lower than the statewide average. One MCO, FHP, had four rates substantially lower than the statewide average rates; one MCO, DHMP, had three rates substantially lower than the statewide average rate; and two MCOs, RMHP and Kaiser, had only one rate substantially lower than the statewide average rate. For two measures—*Rating of Personal Doctor* and *Rating of Health Plan*—two health plans had rates substantially lower than the statewide averages. For five measures—*Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*—only one health plan had a rate substantially lower than the statewide averages. The Department may want to consider statewide initiatives or studies to further evaluate the key drivers that impact these rates.

Validation of Network Adequacy

Statewide Results

The Department actively participated in the network adequacy activities, supplying network process documentation and provider data from the interChange data system. However, provider data in interChange supports FFS data processes (e.g., processing healthcare claims) and has no mechanism to capture data on a provider's FFS and/or health plan affiliation(s). Additionally, the Department reported that it does not routinely collect the health plans' provider network data files and does not require health plans to use a standardized set of definitions for identifying specific provider categories. Furthermore, the structure in which interChange maintains provider data affects the availability and completeness of provider attributes. Providers' degree, title, and/or credentialing information is required for selected provider types when enrolling in interChange (e.g., providers or facilities must submit documentation confirming that they meet the criteria for the given provider type). Consequently, providers' degree, title, and/or credentialing information is not captured in separate interChange data elements but may be inferred based on the provider type.

Each health plan participated in the network adequacy activities, supplying documentation and provider data to HSAG. While all health plans reported on their approaches for collecting and maintaining their provider data, specific activities varied by health plan. Each health plan reported that it identifies group and/or facility-level providers, though many health plans included no provider type values for facilities (e.g., hospitals or multi-specialty practices), indicating that each health plan handles records differently for these provider categories compared to data for the individual-level providers. Additionally, not every health plan reported that it collects providers' taxonomy code(s), limiting the use of this provider attribute when creating a standardized crosswalk of provider category definitions. Finally, each health plan's provider data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map the provider data to the Department's provider categories (i.e., generate provider crosswalks). Disparities in provider data elements available from the Department and the health plans also prevented HSAG from reliably identifying the same provider from both the interChange and the health plans' data sets.

Statewide Conclusions and Recommendations

The health plans' data completeness and consistency affected the range of attribute combinations recommended for each provider category in the provider crosswalks. When HSAG determined that a health plan's data was missing provider type values or contained overly broad specialty information (e.g., a specialty of "Nurse Practitioner"), HSAG may have required taxonomy, degree, or credential data to determine whether the provider could be counted in a specific PCA category. Behavioral health provider categories for the CHP+ MCOs required licensure information (e.g., licensed clinical social workers), and the CHP+ health plans generally had sufficient provider attribute data to assign potential providers to the Department's approved provider categories. However, for other provider types, many health plans' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., NPs or PAs). While these health plans collected detailed subspecialty information for physicians, similar information was not reported for the non-physician providers.

PCA results illustrated the need for standardized provider category definitions when conducting network adequacy assessments to ensure consistent analytic results across health plans. The PCA results also reinforced the need for the health plans to evaluate the level of specificity available in their provider data systems. Additionally, interChange provider data include hospitals, FQHCs, RHCs, and CMHCs; however, the health plans may not have these providers counted in the PCA due to the way in which these providers are reflected in the health plans' data.

As the first comprehensive investigation into the health plans' provider networks, the current study established a foundation from which to build robust managed care network adequacy expectations and processes for overseeing the health plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the health plan. The Department should also develop standardized quarterly network adequacy reporting templates for each health plan type. To ensure consistent reporting within each health plan type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps
    - Content should allow the health plan to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206[4-19] and reporting requirements under 42 CFR §438.207[4-20]

[4-19] Availability of Services, 42 CFR §438.206. Available at https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8. Accessed on May 20, 2019.

[4-20] Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207. Accessed on May 20, 2019.

  - Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the health plan
  - Methodology information for any expected calculations
    - For example, time/distance calculations should be based on driving distances between each member and the nearest applicable provider
  - Templates for any expected data tables, including definitions for each cell that the health plan is expected to populate
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the health plans and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the health plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. The health plans should assess available data values in their provider data systems and standardize available data value options.

5. Assessment of CHP+ Health Plan Follow-Up on Prior Recommendations

Colorado Access (COA)

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*). COA had no required actions related to Standard V—Member Information or Standard VII—Provider Participation and Program Integrity.

For Standard VI—Grievance and Appeal System, COA had one required action:

- Ensure that appeal resolution letters to members are written in language that may be easily understood by the members.

COA submitted its initial corrective action plan proposal on February 25, 2018, and following Department approval completed implementation of all planned interventions on December 3, 2018.

Validation of Performance Measures

HSAG recommended that COA work to ensure that members receive follow-up care for children receiving antipsychotic medications, childhood immunizations, and nutrition counseling for children and adolescents.

To follow up on these recommendations related to the FY 2017–2018 PMV, COA responded with the following:

- Interventions related to children receiving antipsychotic medications in the coming year (e.g., messaging to the provider network about the clinical necessity for this service, billing codes, etc.) in an effort to improve future HEDIS scores.
- Childhood immunization status increased an average of 6.94 percentage points for all measure indicators, with the minimum increase being just over 4 percentage points and the largest just over 9 percentage points. These increases are due to 104 new site locations for Safeway pharmacies and 48 sites for CVS and Target, with a total of 848 new sites going live between 2017 and 2018.
- COA regularly engages members in regard to their nutrition; one example is the HeLP program (Healthy Living Program), a grant funded by the Colorado Department of Public Health and Environment and in partnership with the Colorado Department of Pediatrics, Section of Nutrition, which has been running for the last two years.

Validation of Performance Improvement Projects

In FY 2017–2018, COA closed out a PIP focused on improving the percentage of members with a chronic medical or mental illness who received care management outreach within 90 days of their 19th birthday. At the conclusion of COA's PIP, HSAG recommended the following:

- Document a thorough and complete interpretation of study indicator results for each measurement period to monitor and communicate progress toward meeting outcome-related goals.
- Consider spreading successful improvement strategies to other populations or other identified areas in need of improvement. Use iterative quality improvement science techniques, such as the PDSA model, to test an intervention on a small scale, evaluate initial results, and then gradually expand to full implementation, if the intervention is deemed successful.
- Develop a sustainability plan within the organization and in collaboration with any key partners to ensure that the improvement demonstrated through the PIP is maintained beyond the life of the PIP.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, COA developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, COA will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, COA will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, COA will report final SMART Aim measure results and develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess COA's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, COA reported engaging in the following quality improvement initiatives:

- As part of COA's PIP for well-visits for 10–14 year old members, COA has incorporated a study that looks at how effective the clinic is at scheduling a well-visit at the time that a member is already in the office as well as no-show rates for appointments scheduled as a result of the clinic's enhanced telephone outreach to members.
- COA partners with provider groups to designate them as Enhanced Clinical Partner Primary Care Providers. COA offers an enhanced per-member-per-month payment to these providers who deliver required enhanced services including: (1) have weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday–Friday, 7:30 a.m.–5:30 p.m.) or school hours for SBHCs, and (2) provide 24/7 phone coverage with access to a clinician that can assess the degree of the member's health need.
- COA has implemented a standard call monitoring program that audits staff members' customer service and soft skills weekly. Also, COA continuously gauges members' experience of care from the customer service department through a Net Promoter System survey. Members of the customer

service department have individualized professional development plans to increase customer service skills. Additionally, the customer service department continues to assess providers' customer service skills through the evaluation of grievances submitted by members.

Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

Denver Health Medical Plan, Inc. (DHMP)

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable)*.

For Standard V—Member Information, DHMP had two required actions:

- Revise its member handbook to include accurate time frames for filing grievances and appeals and requesting a State fair hearing.
- Revise its member handbook to inform members how to access benefits available under the State plan but not covered by DHMP.

For Standard VI—Grievance and Appeal System, DHMP had two required actions:

- Ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.
- Ensure that all providers and subcontractors are provided with information about the grievance, appeal, and State fair hearing system upon entering into contracts with DHMP.

For Standard VII—Provider Participation and Program Integrity, DHMP had three required actions:

- Have mechanisms for screening provider claims for potential fraud, waste, or abuse, reporting to the Department all overpayments related to potential fraud, and reporting to the Department changes in a network provider's circumstances that may affect the provider's ability to participate in the managed care program.
- Have documented procedures for notifying the Department of prohibited affiliations, ownership and control, and any excess capitation payments made.
- Have mechanisms for ensuring that network providers report and return overpayments to DHMP and that DHMP reports recovery of overpayments to the Department.

DHMP submitted its initial corrective action plan proposal on February 26, 2018, and following Department approval completed implementation of all planned interventions on June 5, 2019.

Validation of Performance Measures

HSAG recommended that DHMP work to ensure that members receive medications necessary to treat their conditions and that providers appropriately monitor members receiving long-term medications.

To follow up on these recommendations, DHMP responded with the following:

- The pharmacy department reviews all prior authorization (PA) requests quarterly by number of requests and top requested drugs by cost to regularly evaluate if continued PA is appropriate, to identify drugs that should be added to the formulary or to determine if modifications to the formulary UM in place is needed.
- An annual Pharmacy Member Survey is performed regarding pharmacy benefits and experience using the pharmacy network.
- The Drug Utilization Review (DUR) Committee works with DHMP staff members that administer Denver Health Medicaid Choice to oversee and improve members' quality of clinical care and safety.

HSAG also recommended that DHMP work to ensure that members have access to care and receive these services.

To follow up on these recommendations, DHMP responded with the following:

- The marketing department produces and distributes annual quick reference guides to educate members about how and where to receive care, which are mailed to all members.
- An annual Pharmacy Member Survey is performed regarding pharmacy benefits and experience using the pharmacy network. This survey also provides members the opportunity to leave specific comments or request follow up from the health plan.
- Integrated the use of quarterly reporting through the appointment center that shows the number of appointments that Medicaid member's access for PCPs and specialists. This report helps to identify any potential gaps in services or appointment times.

Validation of Performance Improvement Projects

In FY 2017–2018, DHMP closed out a PIP focused on improving the follow-up visit rate for members with asthma who visited an ED, urgent care, or an inpatient facility. At the conclusion of DHMP's PIP, HSAG recommended the following:

- Consider using other quality improvement tools, such as a process map or FMEA, to isolate barriers or gaps within processes that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.
- For improvement strategies that were deemed successful, DHMP should develop a plan for sustaining and spreading the success beyond the life of the PIP.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, DHMP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, DHMP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, DHMP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, DHMP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess DHMP's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, DHMP reported engaging in the following quality improvement initiatives:

- DHMP continues to improve their quality assurance and training program for staff members. DHMP monitors 10 calls per representative per month and identifies trends for team training and individual issues for one-on-one training. Trainings are conducted each month.
- To address opportunities for improvement with customer service, DHMP runs a report through Customer Relationship Management (CRM) that documents the reasons for incoming calls and common themes that were captured by customer service representatives. As new trends are identified, DHMP provides additional information, refresher training, or new training for new issues identified to customer service representatives.
- DHMP conducted an Annual Member Experience Survey and asked members specific questions about their communication preferences (e.g., information in member handbook was clear, know where to find and get materials, understand DHMP's policies and procedures). DHMP set a top-box goal of 75 percent for each of the questions and two questions exceeded the goal, while three questions fell short of the goal. DHMP's website offers members options to view the site in different formats to meet their needs (e.g., larger font size, line spacing, color contrast). DHMP's marketing department will evaluate the areas that performed below the target top-box rates during

the annual web review process and review opportunities for member education on DHMP's policies and procedures.

- DHMP uses a report generated quarterly through the appointment center that shows the number of appointments that Medicaid members access for specialists. The report helps DHMP identify any potential gaps in services or appointment times. In addition, DHHA began an initiative over a year ago to increase availability for new patient appointments in specialist care clinic visits.
- DHMP's marketing department creates and distributes member newsletters quarterly, which contain content to educate members about various health topics and community and plan resources (e.g., same-day care options, the Denver Health NurseLine, recipes, Denver Public Health).

Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

Friday Health Plans of Colorado (FHP)

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable)*.

For Standard V—Member Information, FHP had one required action:

- Ensure that the member handbook is written in Spanish and available to members upon request.

For Standard VI—Grievance and Appeal System, FHP had four required actions:

- Correct the Grievance and Appeal policy, CHP+ member handbook, and notices of denial to CHP+ members to address requirements related to denial of an expedited appeal request.
- Include specific information in the Grievance and Appeal policy regarding the time frame for member requests for continued benefits during an appeal or State fair hearing.
- Correct the defined criteria for how long requested benefits will continue during an appeal or State fair hearing to comply with revised CHP+ federal regulations.
- Correct grievance and appeal information in the provider manual to similarly reflect all required changes in the Grievance and Appeal policy and procedures.

For Standard VII—Provider Participation and Program Integrity, FHP had one required action:

- Develop written policies and procedures that address provider retention.

FHP submitted its initial corrective action plan proposal on April 9, 2018, and following Department approval completed implementation of all planned interventions on May 6, 2019.

Validation of Performance Measures

HSAG recommended that FHP work to ensure that members have access to primary care, childhood immunizations, weight assessment and counseling, and child and adolescent well-care services.

To follow up on these recommendations, FHP responded with the following:

- FHP developed a list of reports that will be reviewed on a quarterly process looking at under- and overutilization of services. In this review, the QMPC will be reviewing the results and making recommendations for quality improvement related to access to primary care and services and the utilization of such services.

Validation of Performance Improvement Projects

In FY 2017–2018, FHP closed out a PIP focused on improving the transition from primary care to BH follow-up care for adolescents 12 to 17 years of age who screened positive for depression. At the conclusion of FHP's PIP, HSAG recommended the following:

- Revisit the causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers and develop new, active interventions, as needed.
- Evaluate the effectiveness of each individual intervention and make data-driven decisions based on the evaluation results.
- Develop a plan to spread or sustain any improvement achieved through the PIP process.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, FHP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, FHP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, FHP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, FHP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess FHP's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, FHP reported engaging in the following quality improvement initiatives:

- Through its provider relations department, FHP is working on a demographic update that looks at the following to ensure demographic accuracy:
  - General information (e.g., National Provider Identifier (NPI), location address, phone number, fax number, hours, languages, and remit address [if different from service location])
  - Provider newsletter correspondence
  - Credential information
  - Contract information
  - Claims/billing information
  - Medical records information
  - Roster information
- FHP has confirmed that providers are currently leaving slots open for same-day appointments and have incorporated evening and Saturday hours for scheduling purposes. Additionally, FHP is exploring the possibility of offering clinics on Saturdays for certain services (e.g., well-child visits).
- FHP provides Teladoc services to members that deliver additional resources when it is not feasible for members to attend a face-to-face appointment.
- FHP continues to offer many cultural competency trainings to its providers.
- FHP has translated and offers member-specific communication templates in Spanish. FHP provides these Spanish materials to members upon request.

Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

Kaiser Permanente Colorado (Kaiser)

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable)*. Kaiser had no required actions related to Standard V—Member Information.

For Standard VI—Grievance and Appeal System, Kaiser had seven required actions:

- Three required actions regarding CHP+ member written communications related to grievances: acknowledgement of receipt of a grievance, written disposition of the grievance, and ensure including all required information in the grievance disposition letter.
- Two required actions regarding CHP+ appeal communications: ensure that the resolution letter may be easily understood by the member and that it includes circumstances in which the member may be held liable for the cost of continued benefits pending the outcome of an appeal.
- Revise the appeals policy and CHP+ member handbook to specify that the representative of a deceased member's estate is a party to the State fair hearing process.
- Correct the defined criteria for how long requested benefits will continue during an appeal or State fair hearing to comply with revised CHP+ federal regulations.

For Standard VII—Provider Participation and Program Integrity, Kaiser had one required action:

- Develop a written policy for retention of providers.

Kaiser submitted its initial corrective action plan proposal on April 6, 2018, and following Department approval completed implementation of all planned interventions on March 19, 2019.

Validation of Performance Measures

HSAG recommended that Kaiser work to ensure that members have access to child and adolescent well-care services and medication management for children receiving asthma medications.

To follow up on these recommendations related to the FY 2017–2018 PMV, Kaiser responded with the following:

- Kaiser created new workflows that were developed since the release of the asthma care coordinator roles (registered nurses [RNs]). These new workflows contain the following initiatives:
  - Chronic obstructive pulmonary disease (COPD) patients are being followed by the care management registered nurses/team post-ED visit and/or hospitalization.

- Adult and pediatric asthma patients are being followed by allergy RNs/teams post-ED visit and/or hospitalization.
- Follow-up outreach calls are made within 24–48 hours post-discharge.
- Asthma medication refills are being processed by primary care teams after refill authorization requests (RARs) are sent from the pharmacy refill team.

Validation of Performance Improvement Projects

In FY 2017–2018, Kaiser closed out a PIP focused on improving BH follow-up for CHP+ members 13–17 years of age who screened positive for depression with a PCP. At the conclusion of Kaiser's PIP, HSAG recommended the following:

- Continue to evaluate the effectiveness of each individual intervention and make changes, as necessary.
- Develop a plan to spread or sustain the improvement achieved through the PIP process.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, Kaiser developed the foundation for a project that will address the prior recommendations. In Module 4, Kaiser will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, Kaiser will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess Kaiser's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, Kaiser reported engaging in the following quality improvement initiatives:

- Kaiser continues to hire providers based on the following year's expected membership. Additionally, Kaiser has increased access due to its staffing model through a variety and number of appointment slot times, as well as the availability of telehealth visits. In order to provide quality specialty care for its pediatric members, Kaiser has established key relationships with the highest quality pediatric specialty care providers in Colorado.
- Kaiser has focused on making significant improvements to its online scheduling and improving the functionality of its systems. Kaiser has expanded access in every medical office and community through convenient care. Kaiser continues to offer services such as a Nurse Advice Line 24/7, Chat with a Doctor online, Chat with a Financial Counselor online, Chat with a Pharmacist online, and scheduled telephone and video visits. Also, Kaiser has extended providers' office hours and offers Saturday hours, as well as urgent care within certain medical offices and locations, which has increased the percentage of Kaiser's same-day appointments available.
- To effectively determine member-specific forms of communication, Kaiser continues to have a Best Practice Alert (BPA) for race, ethnicity, and language preference. Kaiser allows members to choose

how they would like to receive information: 1) in-person, 2) video, or 3) phone. Kaiser utilizes pop-up screens in each department if the member's preferences have not been updated.

Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

Rocky Mountain Health Plans (RMHP)

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable).* RMHP had no required actions related to Standard V—Member Information.

For Standard VI—Grievance and Appeal System, RMHP had four required actions:

- Ensure that each member receives a written acknowledgement of a grievance and a written acknowledgement of an appeal within two days of receipt.
- Ensure that each grievance and each appeal is resolved and that a written notice of resolution is sent to the member within the required time frames.

For Standard VII—Provider Participation and Program Integrity, RMHP had one required action:

- Implement a method to verify whether services represented to have been delivered by network providers were actually received by members.

RMHP submitted its initial corrective action plan proposal on April 2, 2018, and following Department approval completed implementation of all planned interventions on January 7, 2019.

Validation of Performance Measures

HSAG recommended that RMHP work to ensure that members have access to care and receive access to adolescent primary care, well-child visits, and childhood immunization services.

To follow up on these recommendations, RMHP responded with the following:

- RMHP has information in member-facing educational materials that directs the member to contact customer service at the One-Call phone number, if/when there is a question related to benefits or services offered under its plan.

- RMHP focused on reaching CHP+ members with asthma aging out of the program in order to encourage them to schedule a visit with their provider before coverage ended.
- The RMHP QI department sends incentive mailings to CHP+ members to remind them to complete their scheduled childhood immunizations.

Validation of Performance Improvement Projects

In FY 2017–2018, RMHP closed out a PIP focused on improving the transition of care process for members with asthma who will be aging out of the CHP+ plan. At the conclusion of RMHP's PIP, HSAG recommended the following:

- Regularly revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and consider new innovative impactful interventions.
- Consider using an FMEA, in addition to a process map, to isolate barriers that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, RMHP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, RMHP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, RMHP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, RMHP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess RMHP's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, RMHP reported engaging in the following quality improvement initiatives:

- RMHP is a "Partner in Quality" with NCQA; therefore, RMHP practices that are PCMH have a requirement to offer expanded hours of availability, and RMHP supports practices in PCMH transformation. RMHP incentivizes practices for being a higher tiered practice in the RMHP Value-Based Tiered Payment Model. Tier 1 practices are required to be a PCMH. In addition, the Access Measures under the State Alternative Payment Model Program are monitored by the RMHP Practice Transformation Team.
- RMHP conducts a quarterly Provider Attributes survey. Implemented in November 2018, this survey template is sent to all network providers and requests any updates from the provider, including availability of hours. RMHP is developing a database to capture this information more

efficiently and allow RMHP to populate the print and online directories. This development should be fully incorporated by the end of August 2019.

- RMHP continually strives to ensure that its provider network is sufficient so that services are provided to members on a timely basis. RMHP uses a variety of means to educate providers about the various behavioral health and physical health appointment standards.
- RMHP surveys members annually regarding their experience with timeliness of appointments.
- RMHP provides members and providers access to the directory on its website where they can easily search for after-hours care and urgent care providers.

Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

Delta Dental of Colorado

FY 2018–2019 was the first year that HSAG performed the EQR-related activities for Delta Dental. Therefore, no follow-up is reported.

Appendix A. FHP Administrative and Hybrid Rates

Table A-1 shows FHP's rates for HEDIS 2019 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2019 hybrid rate.

Table A-1—HEDIS 2019 Administrative and Hybrid Performance Measure Results for FHP

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Childhood Immunization Status			
Combination 2	4.76%	47.62%	<10th
Combination 3	4.76%	47.62%	<10th
Combination 4	4.76%	45.24%	<10th
Combination 5	4.76%	38.10%	<10th
Combination 6	0.00%	28.57%	10th–24th
Combination 7	4.76%	38.10%	<10th
Combination 8	0.00%	28.57%	10th–24th
Combination 9	0.00%	23.81%	<10th
Combination 10	0.00%	23.81%	10th–24th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	26.32%	38.60%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	12.28%	17.54%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	55.62%	58.58%	<10th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	37.65%	48.53%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	9.70%	33.74%	<10th
Counseling for Nutrition—Total	4.65%	40.20%	<10th
Counseling for Physical Activity—Total	6.26%	37.98%	<10th