FY 2019–2020 External Quality Review Technical Report for Child Health Plan *Plus*

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Colorado's CHP+ Managed Care Quality Strategy

The Health First Colorado 2020 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 states' Quality Strategies. As recommended by CMS, the Department of Health Care Policy and Financing's (the Department's) Quality Strategy provides a blueprint for advancing the State's commitment to improving quality healthcare delivered through Colorado's managed care health plans.

The Department contracts with five managed care organizations (MCOs) and one dental prepaid ambulatory health plan (PAHP) to provide comprehensive healthcare services for members eligible for health insurance under the federal Children's Health Insurance Program (CHIP). Child Health Plan *Plus* (CHP+) is Colorado's implementation of the CHIP. The Department requires its five CHP+ MCOs and one dental PAHP to participate in the four mandatory external quality review (EQR) activities (compliance reviews, validation of performance measures using HEDIS methodology, validation of performance improvement projects [PIPs], and validation of network adequacy). Colorado does not exempt any of its CHP+ MCOs from EQR. In addition, the Department further leverages its external quality review organization (EQRO) to conduct CAHPS surveys for Colorado's CHP+ population. This report describes the findings of EQR-related activities and provides an assessment of the quality, timeliness, and access to care provided by Colorado's CHP+ managed care health plans as required by 42 Code of Federal Regulations (CFR) §438.358. The MCOs and PAHP are collectively referred to as "health plans" throughout this report.

Summary of FY 2019–2020 Statewide Performance by External Quality Review Activity With Trends

Assessment of Compliance With CHIP Managed Care Regulations

In fiscal year (FY) 2019–2020, Health Services Advisory Group, Inc. (HSAG) reviewed two standards as directed by the Department (see Section 2—Reader's Guide, Methodology). To assist the CHP+ MCOs with understanding revisions to the Medicaid and CHIP managed care regulations released in May 2016, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions.

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+ Health Plans

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)**	**94%**	**78%**
Standard II—Access and Availability (2013–2014, 2016–2017, 2019–2020)**	**93%**	**90%**
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 Systems (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
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	88%	87%

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

***Bold text indicates standards reviewed by HSAG during FY 2019–2020.*

Colorado's CHP+ MCOs demonstrated improved statewide performance in the most recent cycle of review for four of the 10 standards as compared to the previous year the standards were reviewed. For the standards with improved performance, three of the four standards, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard VI—Grievance and Appeal Systems, improved substantially (10 percentage points or more) compared to the previous year the standard was reviewed. Two standards, Standard VII—Provider Participation and Program Integrity and Standard X—Quality Assessment and Performance Improvement, remained relatively stable. In one standard, Standard I—Coverage and Authorization of Services, performance decreased substantially. Two standards, Standard III—Coordination and Continuity of Care and Standard and Standard II—Access and Availability experienced a slight decline (5 percentage points of less) in performance. Due to new or revised federal requirements for Standard IX—Subcontracts and Delegation, HSAG scored requirements

[1-1] In FY 2019–2020 the Department contracted with one dental PAHP. Therefore, no statewide performance or trend information related to dental care is included in this table. For complete EQR findings for the State's dental PAHP, see Section 3.

in this standard as not applicable to CHP+ MCOs in FY 2017–2018; therefore, no statewide comparative results are available for Standard IX. For individual health plan scores and findings, see Section 3. For the health plan comparison of scores for FY 2019–2020 standards, see Section 4, Table 4-1.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

CHP+ MCOs' statewide performance in five out of nine applicable standards was 90 percent overall compliance or better. In four standards, performance remained below 90 percent compliant. During the comparative review cycle, federal managed care regulations, including updated regulations released May 2016 (effective for CHP+ health plans as of July 1, 2018), may have changed and may have contributed to performance declines.

Based on the performance trends seen in Table 1-1, HSAG recommends that the CHP+ health plans continue to incorporate and implement processes designed to ensure compliance with federal managed care regulations released May 2016 (effective for CHP+ health plans as of July 1, 2018), paying particular attention to those standards with less than 90 percent overall performance: Standard I—Coverage and Authorization of Services, Standard III—Coordination and Continuity of Care, Standard VI—Grievance and Appeal Systems, and Standard X—Quality Assessment and Performance Improvement.

Validation of Performance Measures

Information Systems Standards Review

HSAG reviewed the Final Audit Reports (FARs) produced by each MCO's NCQA-certified HEDIS compliance auditor. Each FAR included the auditor's evaluation of the MCO's information systems (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 CHP+ statewide weighted averages for HEDIS 2018 through HEDIS 2020, along with the percentile ranking for each HEDIS 2020 rate for the high- and low-performing measure rates. Statewide performance measure results for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019, when available. 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 2019 since this indicator is not published in Quality Compass. Rates for HEDIS 2020 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2020 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-2] Additional CHP+ statewide weighted average measure rates can be found in Section 4.

Table 1-2—Colorado CHP+ Statewide Weighted Averages—HEDIS 2020 High Performers

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 9	36.49%	42.27%	42.44%	75th–89th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.07%	0.04%	0.04%	≥90th
Respiratory Conditions				
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	61.29%	59.75%	65.12%	75th–89th
Medication Compliance 50%—Ages 12 to 18 Years	51.75%	51.64%	63.16%	75th–89th
Medication Compliance 75%—Ages 5 to 11 Years	32.26%	33.96%	38.95%	75th–89th
Medication Compliance 75%—Ages 12 to 18 Years	24.48%	27.05%	41.35%^	75th–89th
Asthma Medication Ratio				
Ages 5 to 11 Years	82.90%	82.63%	88.44%	≥90th

** For this indicator, a lower rate indicates better performance.*
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

The HEDIS 2020 statewide weighted average for the *Childhood Immunization Status—Combination 9* measure within the Pediatric Care domain demonstrated strength with vaccinations for children and adolescents, exceeding the 75th percentile. Of note, DHMP and Kaiser exceed the 90th percentile for this measure indicator.

The HEDIS 2020 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 unnecessarily screening young women for cervical cancer.

[1-2] Performance comparisons are based on the Chi-square test of statistical significance with a *p* value < 0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2019 rates may be understated or overstated.

For the Respiratory Conditions domain, the statewide average rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years* and *Ages 12 to 18 Years* and *Medication Compliance 75%—Ages 5 to 11 Years* and *Ages 12 to 18 Years* performed above the 75th percentile, while the *Asthma Medication Ratio—Ages 5 to 11 Years* measure exceeded the 90th percentile. The *Asthma Medication Ratio* measure is 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+ Statewide Weighted Averages—HEDIS 2020 Low Performers

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	62.54%	66.78%	63.39%	10th–24th
Combination 3	61.05%	65.16%	61.81%	10th–24th
Combination 4	59.17%	63.13%	60.55%	10th–24th
Combination 5	53.79%	59.76%	**54.80%^^**	10th–24th
Combination 7	52.43%	58.20%	**53.94%^^**	25th–49th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	2.63%	5.06%	4.66%	<10th
Six or More Visits	51.41%	48.28%	56.22%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	19.89%	22.71%	22.62%	<10th
Counseling for Nutrition—Total	20.12%	21.46%	20.77%	<10th
Counseling for Physical Activity—Total	15.87%	17.58%	16.17%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	90.65%	92.33%	92.44%	10th–24th
Ages 7 to 11 Years	87.49%	87.66%	87.58%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	33.66%	36.52%	37.26%	<10th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	21.84%	15.21%	14.98%	<10th
Continuation and Maintenance Phase	21.57%	20.00%	32.69%	<10th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered with caution.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

The HEDIS 2020 statewide weighted average for measures within the Pediatric Care domain demonstrated opportunities for improvement, as nine of 10 (90.0 percent) measures fell below the 25th percentile. However, the one measure indicator that did exceed the 25th percentile (*Childhood Immunizations Status—Combination 7)* demonstrated a significant decline in performance from the previous year. Conversely, the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure indicator demonstrated a significant improvement in performance from the previous year. The Department and the MCOs should focus 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 that 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 both of the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators. Only one indicator rate for the MCOs (RMHP, *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 2020, indicating opportunities exist to increase screenings for chlamydia for young women.

The measures determined to be low performers for HEDIS 2020 within the Mental/Behavioral Health domain were mainly representative of the performance of COA, as all but one rate for the remaining MCOs were not reportable because the denominator was less than 30. Therefore, caution should be exercised when comparing trends in rates as the statewide weighted average is based off a small population of members prescribed medications for behavioral health conditions.

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 the IS standards review.

[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: Sept 14, 2020.

The following HEDIS 2020 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with a significant decline in performance from HEDIS 2019) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2*, *3*, *4*, *5*, and *7*
- *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 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*

Statewide performance for HEDIS 2020 demonstrated opportunities to improve the access to preventive care and services for members, including chlamydia screening and follow-up care for members prescribed attention-deficit/hyperactivity disorder (ADHD) medications.

Validation of Performance Improvement Projects

Table 1-4 summarizes PIP performance for each CHP+ health plan in FY 2019–2020. Each CHP+ health plan conducted a PIP focusing on a topic related to access to care. Table 1-4 also summarizes how far through the five modules of the rapid-cycle PIP process each CHP+ health plan progressed.

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 3 and Initiated Module 4*	NA*
DHMP	*Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
FHP	*Well-Child Visits in the 6th Through 14th Years of Life*	*Completed Module 3 and Initiated Module 4*	NA*
Kaiser	*Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
RMHP	*Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	*Completed Module 3 and Initiated Module 4*	NA*

Health Plan	PIP Topic	Module Status	Validation Status
DentaQuest	*Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*	*Completed Modules 1 through 3 and Initiated Module 4*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2019–2020 validation cycle.*

During this validation cycle, the CHP+ health plans completed Module 3—*Intervention Determination* and initiated intervention testing for Module 4—*Plan-Do-Study-Act.* In Module 3, each CHP+ health plan used process mapping and a failure modes and effects analysis (FMEA) to identify opportunities for improving the process or processes related to the SMART (specific, measurable, attainable, relevant, and time-bound) Aim for the PIP. Module 3 also included identification of interventions to address the identified opportunities for process improvement. The initiation of Module 4 included selecting one or more interventions to test through Plan-Do-Study-Act (PDSA) cycles and developing an intervention evaluation plan. One CHP+ health plan, DentaQuest, initiated the PIP and also completed Module 1 and Module 2 in FY 2019–2020, prior to progressing to Module 3.

After each CHP+ health plan submitted Module 3 for validation, HSAG provided feedback in the Module 3 validation tool. If any Module 3 validation criteria were not achieved, the CHP+ health plan had the opportunity to seek technical assistance from HSAG. Each CHP+ health plan resubmitted Module 3, and received feedback and technical assistance, until all validation criteria were achieved. While the CHP+ health plans initiated intervention testing for Module 4 during FY 2019–2020, this module can take up to 12 months or more and can span more than one FY; therefore, HSAG did not validate the health plans' performance on Module 4 during FY 2019–2020. As noted in the "Validation Status" column in the table, no PIPs progressed to being evaluated on outcomes or receiving a final validation status. Due to the coronavirus disease 2019 (COVID-19) pandemic, the Department decided to close out the PIPs at the end of FY 2019–2020, prior to the completion of Module 4 and Module 5. The CHP+ health plans were instructed to submit a PIP close-out report and will initiate a new round of PIPs in FY 2020–2021.

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

The CHP+ health plans achieved all validation criteria for Module 3 of the PIPs; therefore, there were no identified opportunities for improvement, based on the FY 2019–2020 PIP validation findings. Although the PIPs were closed out early, due to the COVID-19 pandemic, the CHP+ health plans will have lessons learned from working on Colorado's first round of rapid-cycle PIPs. In order to capture knowledge gained and lessons learned from the CHP+ health plans' FY 2019–2020 PIP activities, HSAG recommended to the Department that the CHP+ health plans' PIP close-out reports include intervention testing summaries, challenges encountered, successes achieved, and lessons learned. Common challenges, successes, and lessons learned reported in the PIP close-out reports were shared with the Department and CHP+ health plans at the September 2020 Colorado PIP Summit. Based on

common themes included in the close-out reports, HSAG recommended the following to facilitate success in the next round of rapid-cycle PIPs:

- Foster understanding and commitment among external partners that are an integral part of intervention testing and data collection for the rapid-cycle PIPs.
- Allow sufficient time to develop interventions and address data collection issues. Consider the end date of the project and develop project management dates accordingly.
- Ensure adequate and consistent staffing for PIP activities. Develop a transition plan to sustain PIP activities in the event of staff turnover within the CHP+ health plan or external partner organization.

CAHPS Surveys

Table 1-5 shows the statewide average results for each CAHPS measure for FY 2017–2018 through FY 2019–2020. The statewide averages presented in Table 1-5 are derived from the combined results of the five CHP+ MCOs.[1-4]

Table 1-5—Top-Box Scores for the Colorado CHP+ Program

Measure	FY 2017–2018 Statewide Aggregate Rate	FY 2018–2019 Statewide Aggregate Rate	FY 2019–2020 Statewide Aggregate Rate
Getting Needed Care	85.5%	87.1%	83.7%
Getting Care Quickly	91.2%	90.5%	90.9%
How Well Doctors Communicate	95.8%	95.4%	97.5% ▲
Customer Service	84.1%	84.0%	82.3%
Rating of Health Plan	61.4%	67.1%	63.3%
Rating of All Health Care	68.1%	67.1%	68.8%
Rating of Personal Doctor	75.7%	76.6%	77.6%
Rating of Specialist Seen Most Often	78.7%	77.9%	71.6%

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

▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

Over the three-year period, the following one measure showed an upward score trend, *Rating of Personal Doctor*. Conversely, the *Customer Service* and *Rating of Specialist Seen Most Often* measures showed a downward score trend. The scores for the remaining measures fluctuated, either increasing or decreasing slightly over the periods.

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

The Colorado CHP+ Program scored statistically significant higher in FY 2019–2020 than in FY 2018–2019 on one measure, *How Well Doctors Communicate*.

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 statewide CAHPS results, there were no measures that had a statistically significant decrease in scores from FY 2018–2019 to FY 2019–2020. HSAG observed a downward trend for *Customer Service* and *Rating of Specialist Seen Most Often*, which are quality domain measures. Performance for these measures may be related to a variety of factors including whether members felt treated with courtesy and respect by office staff members and received the services they needed in a timely manner. HSAG recommends that the Department explore what may be driving a decrease in the scores for these measures from FY 2017–2018 to FY 2019–2020 and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

Results

HSAG collaborated with the Department and the CHP+ health plans to develop quarterly network adequacy reporting templates that were implemented by the CHP+ health plans beginning in January 2020. HSAG updated the templates in June 2020 for the CHP+ health plans' use in FY 2020–2021 quarterly network adequacy reporting. Additionally, HSAG conducted baseline network adequacy validation (NAV) analyses of the Medicaid provider networks among the following network domains for the CHP+ health plans (five MCOs, one dental PAHP, and one administrative service organization [ASO]—the State Managed Care Network [SMCN]):

- CHP+ MCOs and SMCN: Primary Care, Prenatal Care, Women's Health Services, Physical Health Specialists, Behavioral Health, Hospitals, and Pharmacies
- PAHP: Dental Primary Care and Dental Specialists

Overall, no CHP+ health plans met all network standards across all counties in each county designation. In general, failure to meet the contract standards was largely attributable to some instances in which the closest network locations were outside the required standard. While plans did not meet the network standards in selected rural and frontier counties, these CHP+ health plans were responsible for only a small number of members (i.e., fewer than 50 members) in each of these rural and frontier counties. Except for DHMP CHP+ and RMHP CHP+, no CHP+ health plans reported Pediatric Primary Care (Mid-Level) practitioners in their network data. Additionally, four CHP+ health plans did not have a sufficient number of Pediatric Ophthalmology practitioners to meet the network standards for their members in selected counties. Each CHP+ health plan, however, reported an adequate overall number of primary care practitioners (i.e., Adult and Pediatric Primary Care Providers, Gynecologists, Family

Practitioners) across each county type, though the CHP+ health plan may not have had adequate network locations to meet each network standard in each county.

Likewise, overall, DentaQuest did not meet all network standards across all counties in each county designation. DentaQuest reported low rates of specialty dental practitioners in rural and frontier counties and extremely low rates of prosthodontists in urban counties. However, DentaQuest reported an adequate number of dental practitioners for the primary dental care network categories (e.g., General Dentists, Pediatric Dentists, and Dental Hygienists).

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

Based on the first standardized calculations of the CHP+ health plans' compliance with network adequacy geoaccess standards, HSAG offers the following recommendations to improve network adequacy data and oversight:

- The Department made significant progress during FY 2019–2020 in developing and implementing quarterly network adequacy reporting materials that are standardized within and across health plan types (e.g., CHP+ MCOs, SMCN, and PAHP). The Department should continue to refine and automate the quarterly network adequacy reporting process to reduce duplication of reporting and oversight efforts for the Department and the health plans, and to facilitate routine NAV by an external entity.
- HSAG's network data review identified varying levels of missingness by health plan for network category assignments, as well as spelling variations and/or use of special characters for the health plans' data values for provider type, specialty, and credentials.
  - The health plans should continue to assess available data values in their network data systems and standardize available data value options and network category attribution.
  - The Department should incorporate data verification processes into the quarterly network adequacy report reviews.
- The Department should review the network categories for which the health plans failed to meet the time/distance standards, and request that the health plans confirm whether failure to meet the time/distance network access standard(s) resulted from concerns with the health plan's network category data attributions, a lack of network locations for the specific geographic area, or the health plan's inability to contract with available network locations in the geographic area.
- The Department should consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data supplied to members and used for geoaccess analyses.
- As the time/distance results represent the potential geographic distribution of contracted network locations and may not directly reflect network availability at any point in time, the Department should consider using appointment availability surveys to evaluate health plans' compliance with contract standards for access to care. HSAG also recommends incorporating encounter data to assess

members' utilization of services, as well as potential gaps in access to care resulting from inadequate network availability.

- In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department should review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care.

Statewide Conclusions and Recommendations

Based on the results of the five EQR-related activities performed during FY 2019–2020, HSAG made the following observations about how these activities provided assessment related to the quality of, timeliness of, and access to care and services. While Colorado's CHP+ statewide performance across EQR activities demonstrated both strengths and opportunities for improvement, Colorado's strongest statewide performance was in the quality domain based on the health plans' internal processes. Statewide, CHP+ health plans demonstrated the ability to provide reliable, valid, and accurate performance measure calculations, and use quality improvement science methodology accurately for process improvement. In addition, most notably, the statewide CHP+ CAHPS score for *How Well Doctor's Communicate* was the highest statewide score at 97.5 percent.

Although statewide CHP+ performance for timeliness and access demonstrated some notable strengths—such as compliant processes for responding to grievances and requests for appeals, and high scores in compliance and CAHPS for customer service, cultural competency, and getting care quickly—Colorado's most significant opportunities for improvement were in the access to care domain. Health plans had processes to monitor the networks; however, based on the NAV activity, HSAG found that no health plan met the time and distance standards set forth by the Department and, through compliance monitoring, health plans largely failed to monitor providers for compliance with timely access standards.

HSAG does, however, recognize that several of the EQR-related activities in FY 2019–2020 were conducted during the COVID-19 pandemic; therefore, results, particularly in the access to care domain, should be considered with caution.

2. Reader's Guide

Report Purpose and Overview

States with CHIP healthcare delivery systems that include health plans are required to annually provide to CMS 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 CHIP). 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 2019–2020. CHP+ health plans in Colorado are listed in Table 2-1.

Table 2-1—Colorado CHP+ Health Plans

Health Plan	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
DentaQuest	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 EQR activities in FY 2019–2020. This section also includes a summary description of relevant trends over a three-year period for each EQR 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 health plans 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 2019–2020. Section 2 also provides an overview of the methodology for each EQR activity performed and how HSAG used data and results 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 activities performed and results obtained.

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.

*Appendix A—CHP+ MCO Administrative and Hybrid Rates p*resents HEDIS results for measure rates with a hybrid option for MCOs that chose to submit using both administrative and hybrid methods. The MCOs were only required to report administrative rates for measures with a hybrid option.

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 conducted 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 Department and with State and federal managed care regulations. HSAG determined compliance through review of two 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 PIPs.** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.
- **Validation of network adequacy.** HSAG reviewed Colorado's existing network adequacy standards and obtained network information from the health plans and the Department to analyze and assess the network needs of the State and to provide technical assistance to the CHP+ health plans regarding data requirements for network adequacy reporting to the Department.

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

- **CAHPS surveys.** HSAG conducted surveys and reported results for all CHP+ health plans on behalf of the Department.

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

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 health plan—e.g., processing appeals and providing timely care.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2-3]

[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*.
[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.

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 2019–2020 site review process, the Department requested a review of two areas of performance based on federal healthcare regulations. The standards chosen were Standard I—Coverage and Authorization of Services, and Standard II—Access and Availability. 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 authorization of services and notices of adverse benefit determination (NABDs).

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.

Technical Methods of Data Collection

To assess for health plans' compliance with regulations, HSAG conducted the five activities described in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-4] Table 2-2 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. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the 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 document 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 each scheduled on-site review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document 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. The health plans also submitted a list of all denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit.

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jul 17, 2020.

For this step,	HSAG completed the following activities:
	• 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 review.
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records related to authorization denials to evaluate implementation of federal managed care regulations and State contract requirements. • While on-site, HSAG also 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 members 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 authorization denials)
- 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+ health plans, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements in each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality of, timeliness of, or access to care and services provided by the health plans. Table 2-3 depicts assignment of the standards to the domains of care.

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

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	✓	✓	
Standard II—Access and Availability		✓	✓

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: A Mandatory EQR-Related Activity,*

October 2019,[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.
  - 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 2020 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

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jun 8, 2020.

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

the audit reports produced by the other licensed audit organizations. Through review of each health plan's FAR, HSAG determined that all licensed organizations (LOs) 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 members. HSAG verified that key HEDIS topics, such as timeliness and on-site review dates, were addressed by the licensed organizations.	HEDIS 2020 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 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 2020 FAR
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 2020 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 2020 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 2020 FAR

Data Reviewed	Source of Data
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 2020 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 2020 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 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 2020 FAR
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 2020 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 2020 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	MRR 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

Information Systems 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 *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. The IS standards are listed as follows:

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

In the measure results tables presented in Section 3, HEDIS 2018, 2019, and 2020 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 2018, 2019, and 2020, 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' measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a p value < 0.05. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the IDSS files for HSAG to use for statistical testing.

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

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

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

Measure results for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure were compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2019 since benchmarks for this measure are not published in Quality Compass. 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 2020. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2020 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 statistically significant decline in performance from HEDIS 2019.
  - Ranked between the 50th and 74th percentiles with statistically significant improvement in performance from HEDIS 2019.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Ranked below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with statistically significant decline in performance from HEDIS 2019.

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 2018, 2019, and 2020 measures be reported using the administrative methodology only. 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 MRR data, as results likely underestimate actual performance. Table 2-6 presents the measures provided in the report that can 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+ health plans' 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+ health plans, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 2-7.

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

Performance Measures	Quality	Timeliness	Access
Pediatric Care			
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	✓		

Performance Measures	Quality	Timeliness	Access
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Access to Care			
*Prenatal and Postpartum Care**	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
Preventive Screening			
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Mental/Behavioral Health			
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Respiratory Conditions			
Appropriate Testing for Pharyngitis	✓		
Appropriate Treatment for Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓		
Medication Management for People With Asthma	✓		
Asthma Medication Ratio	✓		
Use of Services			
Ambulatory Care (Per 1,000 Member Months)	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Antibiotic Utilization	NA	NA	NA

** The CHP+ SMCN was required to report just one measure, Prenatal and Postpartum Care.*
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 CMS *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[2-7]

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.[2-8] 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 CMS *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 PIPs 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.

[2-7] 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: Aug 11, 2020.

[2-8] 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: Aug 11, 2020.

- **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 the interventions and sustain successful changes for improvement achieved.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission form. In FY 2019–2020, these forms provided detailed information about the PIPs and the activities completed for modules 1 through 3 and the activities initiated for Module 4.

Following HSAG's rapid-cycle PIP process, the health plans submitted each module according to the approved timeline. Following the initial validation of each module, HSAG provided feedback in the validation tools. For modules 1 through 3, if validation criteria were not achieved, the health plan had the opportunity to seek technical assistance from HSAG. The health plan resubmitted Module 3 until all validation criteria were met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing. For Module 4, the health plans initiated intervention testing in FY 2019–2020 and received pre-validation feedback from HSAG on the intervention testing plan. The rapid-cycle PIPs span more than one FY and intervention testing for Module 4 lasts up to 12 months or more; therefore, the health plans did not submit Module 4 for validation in FY 2019–2020.

How Conclusions Were Drawn

During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable were not scored. As the PIP progressed, and at the completion of Module 5, HSAG used 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 assigned a level of confidence and reported 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 Project	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 Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	✓		✓
DentaQuest	*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 (41 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 eight measures of experience that included four global ratings and four 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 (+).

Description of Data Obtained

For each of the four global ratings, the percentage of respondents who chose the top ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the CAHPS survey were: (1) "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for the composite measures was defined as a response of "Usually" or "Always." The percentage of top-box responses is referred to as a global proportion for the composite measures.

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

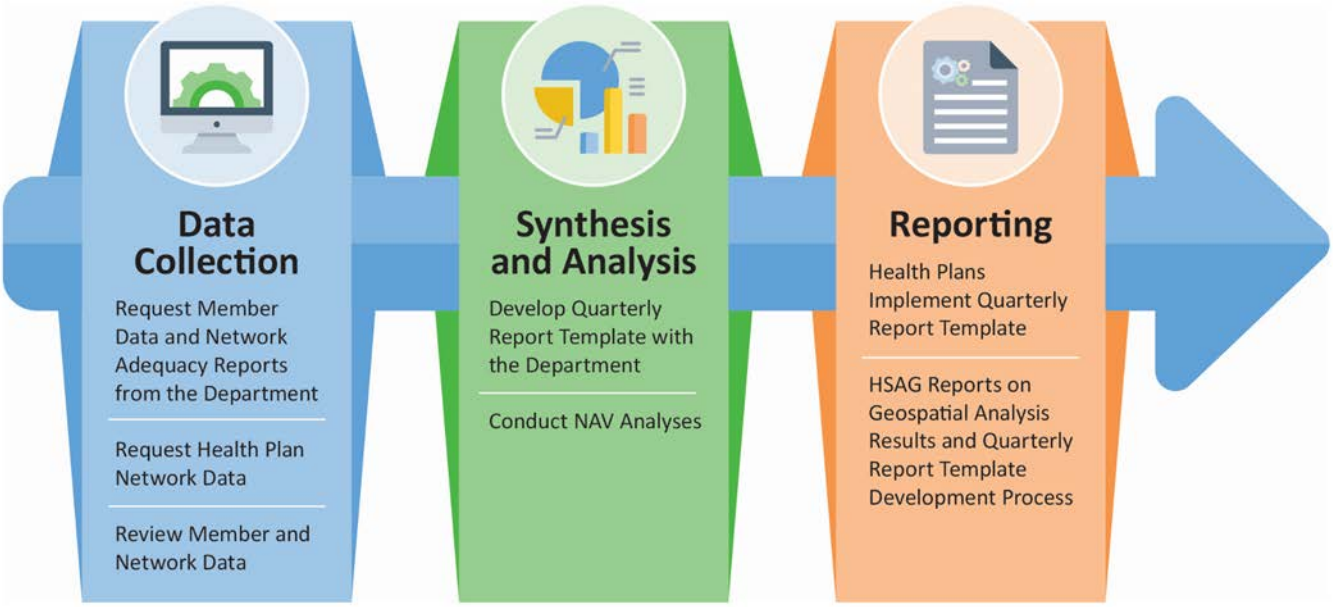
CAHPS Topics	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Validation of Network Adequacy

Objectives

Figure 2-1 describes HSAG's three main phases for the FY 2019–2020 NAV tasks.

Figure 2-1—Summary of FY 2019–2020 Network Adequacy Validation Tasks



HSAG used a desk review approach to collect and review the data used to develop the quarterly network adequacy report templates and conduct the baseline NAV analyses.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the quarterly network adequacy report templates. Analyses and templates included, at a minimum, network categories aligned with the Department's FY 2018–2019 managed care network crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[2-9,2-10] Table 2-10 presents the network domains applicable to CHP+ health plans; within each domain, network categories included in the FY 2019–2020 NAV analyses were limited to categories corresponding to the health plans' contract standards.

[2-9] Network Adequacy Standards, 42 CFR §438.68. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=d748c4b2039bd7ac516211b8a68e5636&mc=true&node=se42.4.438_168&rgn=div8. Accessed on: Aug 28, 2020.

[2-10] The federal network adequacy standard lists the following provider categories that represent common types or specialties of healthcare providers generally needed within a Medicaid population: primary care, adult and pediatric; obstetrics/gynecology (OB/GYN); behavioral health (mental health and substance abuse disorder), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

Table 2-10—Network Domains by Health Plan Type

Network Domain	CHP+ Health Plans	PAHP
Primary Care, Prenatal Care, and Women's Health Services	X	
Physical Health Specialists	X	
Behavioral Health	X	
Facilities (*Hospitals, Pharmacies*)	X	
Ancillary Physical Health Services[1] (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	
Dental Services (*Primary Dental Care and Specialty Services*)		X

[1] For the FY 2019–2020 NAV, geoaccess analyses were limited to pediatric physical therapy, pediatric occupational therapy, and pediatric speech therapy to align with CHP+ network contract standards. These categories are counted with the Physical Health Specialists for all geoaccess results.

Technical Methods of Data Collection

The Department provided HSAG with the model contracts unique to CHP+ health plans to identify network adequacy requirements. To conduct the NAV analyses, HSAG requested CHP+ member data from the Department for members actively enrolled with a CHP+ health plan as of October 1, 2019. HSAG also submitted a detailed network data requirements document to the CHP+ health plans to request data for practitioners, practice sites, and entities actively enrolled with each health plan as of October 1, 2019.

Description of Data Obtained

Quantitative data for the study included member-level data from the Department and provider-level network data from each CHP+ health plan, including data values with provider attributes for type (e.g., nurse practitioner), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code. HSAG used these data to calculate time/distance and ratio results for each CHP+ health plan for each county in which the CHP+ health plan had at least one member identified in the Department's member data file. HSAG used the CHP+ health plans' provider data and the Department's member data to conduct baseline NAV analyses for each CHP+ health plan, evaluating two dimensions of access and availability: network capacity analysis (i.e., provider-to-member ratios) and geographic network distribution analysis (i.e., time and distance metrics).

How Conclusions Were Drawn

HSAG reviewed the current CHP+ health plan contracts and existing quarterly network adequacy reports for each health plan type (e.g., CHP+ MCOs, SMCN, and PAHP), then collaborated with the Department to develop a standardized quarterly network adequacy reporting template and data layout for

the CHP+ health plans. HSAG maintained an iterative process with the Department and the CHP+ health plans to ensure CHP+ health plans could report network adequacy data in a standardized manner.

HSAG used the CHP+ health plans' provider data and the Department's member data to conduct baseline geoaccess analyses specific to each CHP+ health plan.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2019–2020. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

Colorado Access

Assessment of Compliance With CHIP Managed Care Regulations

Colorado Access (COA) Overall Evaluation

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 2019–2020.

Table 3-1—Summary of COA Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	36	32	25	7	0	4	78%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**48**	**41**	**7**	**0**	**4**	**85%***

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

Table 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 2019–2020.

Table 3-2—Summary of COA Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	58	38	20	32	66%
Totals	**90**	**58**	**38**	**20**	**32**	**66%***

**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 utilization management (UM) policies outlined a thorough and comprehensive approach for review and authorization of covered services. COA had established a panel of regularly scheduled

medical reviewers for making CHP+ authorization determinations and routinely offered a peer review consultation to the requesting provider prior to making a final adverse benefit determination (ABD). Denial record reviews demonstrated 100 percent compliance with requirements for application of criteria, decisions made by a qualified reviewer, and outreach to the requesting provider to obtain additional information. Policies and procedures addressed the required content of the NABD and timelines for making authorization decisions. Staff members stated that COA does not ever reduce or terminate previously authorized services. The CHP+ NABDs to members and providers included all required content and were written in a format and language easy for the member to understand. Record reviews demonstrated that all UM denials of *new* authorization requests reviewed were fully compliant with sending notice to the member within required time frames.

COA's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services." COA did not require authorization for emergency services in or out of network and staff members stated that all emergency services claims are auto-paid by the claims system. COA's post-stabilization care policy and procedures outlined some of the procedures for implementing review and payment of post-stabilization services. For post-stabilization services a member receives out of network, staff members stated that COA bills CHP+ members only for applicable co-pays.

COA effectively demonstrated that it monitors and maintains its network of providers to ensure the timely provision of covered services. COA staff members described analysis of gaps in provider availability identified through a variety of tools, including geoaccess reports and HEDIS and CAHPS data. Provider communications informed providers of the timely appointment standards and COA used secret shopper calls to assess compliance with timely appointment standards. COA had policies, procedures, and processes to address cultural competency, including language translation services and tag lines on member-specific communications. Cultural competency training was required for COA staff members and available on the website for providers.

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

Standard I—Coverage and Authorization of Services

On-site denial record reviews identified that NABDs for claims denials were sent only to the provider. Since COA sent no notice to members regarding denial of a claim, record review results were found deficient in several areas, including: "notice sent to provider and member," "correspondence with the member was easy to understand," "notice includes required content,, and "notice sent within required time frame." In addition, while COA's UM policy addressed all required time frames for mailing the NABD to the member, the organization of information in the policy resulted in inaccurate information regarding the time frame for notice of reduction or termination of previously authorized services. COA was required to:

- Ensure that CHP+ members receive written notification of any decision (not related to provider procedural or technical issues) to deny a service, including denial or partial denial of a claim.

- Ensure that the NABD regarding a claim is written in language that is easy for the member to understand, includes all required content, and is sent at the time of any denial affecting the claim.
- Correct the formatting in its UM policy to accurately address all required time frames for mailing the NABD.

COA's post-stabilization care policy and related procedures failed to clearly address how the criteria specified in 42 CFR §422.113(c) are applied when necessary to determine financial responsibility for post-stabilization care and when financial responsibility ends for payment of post-stabilization services that were not pre-approved. COA was required to develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR §422.113(c).

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 (2016–2017, 2019–2020)*	**94%**	**78%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**100%**	**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 Systems (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 2019–2020.*

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

Trended scores over the past two review cycles indicate that COA improved performance in five of the 10 standards, with the greatest improvement (18 percentage points) observed in Standard VI—Grievance and Appeal Systems. In two standard areas, Standard II—Access and Availability and Standard VII—Provider Participation and Program Integrity, COA maintained 100 percent compliance across review cycles. COA experienced an 11 percentage point decline from its previous 100 percent

performance in Standard X—Quality Assessment and Performance Improvement. In the most recent FY 2019–2020 review cycle, COA experienced a 16 percentage point decline in performance in Standard I—Coverage and Authorization of Services. 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. While COA demonstrated consistent performance or improvement across review cycles in seven of 10 standards, HSAG recommends that COA evaluate its systems and processes to renew efforts to achieve high performance in complying with federal and State managed care regulations for Standard I—Coverage and Authorization of Services and Standard X—Quality Assessment and Performance Improvement.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the 2020 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 2018 through HEDIS 2020, along with the percentile rankings for each HEDIS 2020 rate.

Table 3-4—Performance Measure Results for COA

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[2]				
Combination 2	62.30%	71.58%	72.06%	25th–49th
Combination 3	60.82%	69.58%	70.04%	25th–49th
Combination 4	58.71%	66.86%	68.02%	50th–74th
Combination 5	53.96%	63.21%	61.31%	50th–74th
Combination 6	41.29%	49.53%	53.22%	75th–89th
Combination 7	52.38%	61.32%	59.92%	50th–74th
Combination 8	39.92%	48.23%	51.83%	75th–89th
Combination 9	37.59%	45.64%	47.53%	75th–89th
Combination 10	36.54%	44.58%	46.78%	75th–89th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	70.24%	76.30%	76.14%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	31.71%	38.90%	40.19%	50th–74th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	1.36%	6.36%	6.09%	<10th
Six or More Visits	59.86%	47.27%	59.13%^	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	69.32%	68.50%	71.17%	25th–49th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.34%	49.87%	52.24%	25th–49th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[2]	5.25%	9.27%	11.78%	<10th
Counseling for Nutrition—Total	2.94%	5.11%	6.66%	<10th
Counseling for Physical Activity—Total	1.06%	3.14%	4.36%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	94.65%	90.30%	92.29%	10th–24th
Ages 25 Months to 6 Years	85.90%	84.52%	86.12%	25th–49th
Ages 7 to 11 Years	89.74%	87.98%	88.03%	25th–49th
Ages 12 to 19 Years	90.90%	87.78%	87.93%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	32.11%	32.27%	34.07%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.06%	0.08%	0.00%	≥90th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	0.00%	0.00%	0.00%	<10th
Continuation and Maintenance Phase	0.00%	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[3]	—	—	60.58%	—
Cholesterol Testing—Total[3]	—	—	33.65%	—
Blood Glucose and Cholesterol Testing—Total	29.59%	30.49%	30.77%	25th–49th
Respiratory Conditions				
Appropriate Testing for Pharyngitis[3]				
Ages 3 to 17 Years	—	—	85.48%	—
Appropriate Treatment for Upper Respiratory Infection[3]				
Ages 3 Months to 17 Years	—	—	92.27%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[3]				
Ages 3 Months to 17 Years	—	—	72.11%	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Medication Management for People With Asthma[2]				
Medication Compliance 50%—Ages 5 to 11 Years	65.41%	58.41%	62.50%	75th–89th
Medication Compliance 50%—Ages 12 to 18 Years	55.77%	50.00%	60.22%	50th–74th
Medication Compliance 75%—Ages 5 to 11 Years	34.59%	36.28%	40.00%	75th–89th
Medication Compliance 75%—Ages 12 to 18 Years	27.88%	23.33%	35.48%	50th–74th
Asthma Medication Ratio[2]				
Ages 5 to 11 Years	80.58%	83.19%	87.60%	≥90th
Ages 12 to 18 Years	72.07%	75.79%	72.92%	75th–89th
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	26.36	26.90	27.08	≥90th
Outpatient Visits	221.11	218.12	227.68	<10th
Inpatient Utilization—General Hospital/Acute Care[2]				
Discharges per 1,000 Member Months (Total Inpatient)	0.99	1.03	1.02	<10th
Average Length of Stay (Total Inpatient)	3.74	3.43	3.40	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.67	0.74	0.76	<10th
Average Length of Stay (Medicine)	2.85	2.97	2.82	<10th
Discharges per 1,000 Member Months (Surgery)	0.28	0.25	0.23	<10th
Average Length of Stay (Surgery)	6.00	4.90	5.36	<10th
Discharges per 1,000 Member Months (Maternity)	0.09	0.09	0.08	<10th
Average Length of Stay (Maternity)	3.05†	2.58†	3.43†	<10th
Antibiotic Utilization*				
Average Scripts Per Member Per Year (PMPY) for Antibiotics	0.42	0.35	0.35	≥90th
Average Days Supplied per Antibiotic Script	10.88	10.87	10.70	<10th
Average Scripts PMPY for Antibiotics of Concern	0.14	0.12	0.12	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	34.12%	33.71%	33.07%	≥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 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure for 2019, NCQA recommends trending between 2019 and prior years be considered with caution.

[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 lower 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 statistically significant improvement in performance from the previous year.

COA: Strengths

The following HEDIS 2020 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 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS 2019):

- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years* and *Medication Compliance 75%—Ages 5 to 11 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*

For HEDIS 2020, COA demonstrated strong performance with children receiving vaccinations by ranking above the 50th percentile for seven of nine (77.8 percent) measure rates. Additionally, the MCO demonstrated appropriate management of members with asthma and not screening young women unnecessarily for cervical cancer.

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

The following HEDIS 2020 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 a significant decline in performance from HEDIS 2019):

- *Well-Child Visits in the First 15 Months of Life—Zero 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*
- *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 measures, *Children and Adolescents' Access to Primary Care Practitioners*, and *Chlamydia Screening in Women* falling below the 50th percentile. Of note, all three indicators for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* fell below the 10th 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., a lack of family service providers, issues related to barriers to accessing care), and implement strategies to improve the care for young members.

Validation of Performance Improvement Projects

Table 3-5 and Table 3-6 display the FY 2019–2020 validation findings for COA's *Improving Well-Child Visits for Members 10–14 Years of Age* PIP. During FY 2019–2020, COA completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by COA are summarized in Table 3-5.

Table 3-5—Intervention Determination Summary for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Physicians are performing qualifying well visit services during a sick visit but are not billing appropriately	Face-to-face and/or virtual training on appropriate billing practices for well visit services for providers and billing staff members. Training would be accompanied by ongoing support from COA as needed.
Sick visit appointment times cannot be extended to incorporate well visit services	Adding an additional step in the sick visit process flow to ensure that a follow-up well visit appointment is scheduled for members who could not have their sick visit appointment time extended for well visit services. The process change would eventually incorporate digital appointment reminders and provider outreach activities.

COA also initiated Module 4 in FY 2019–2020, selecting two interventions to test and developing the plans for testing through PDSA cycles. Table 3-6 summarizes the interventions COA selected for testing.

Table 3-6—Planned Intervention for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Intervention Description	Key Drivers	Failure Modes
Conduct targeted telephonic outreach to members ages 10–14 who are due or overdue for their annual well visit	Providers have information and processes needed to conduct member outreach to encourage members to schedule an annual well visit	• Members and/or their parents may not receive the mailings or text reminders • Mailings or text reminders may not be sufficient to encourage members and/or their parents to schedule a well visit appointment
Provider and staff member training to ensure well visit services are itemized in the billing process, particularly if these services are added on to other types of appointments	Coding consistencies for well visits across clinic settings	Services are occurring but not being accurately billed or documented

COA: Strengths

COA continued work on a PIP focused on increasing the rate of well-child visits among members 10 to 14 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well-child visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well-child visit. The health plan also successfully initiated Module 4 for the PIP by selecting interventions to test and documenting a plan for evaluating the impact of the interventions through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, COA had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

Findings

Table 3-7 shows the results achieved by COA for FY 2017–2018 through FY 2019–2020.

Table 3-7—Top-Box Scores for COA

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	85.3%	87.7%	83.8%
Getting Care Quickly	92.4%	90.5%	91.1%
How Well Doctors Communicate	95.4%	94.8%	97.7% ▲
Customer Service	83.7%	81.9%	79.9%+
Rating of Health Plan	61.3%	69.3%	62.4%
Rating of All Health Care	69.1%	67.7%	69.5%
Rating of Personal Doctor	76.2%	78.0%	78.2%
Rating of Specialist Seen Most Often	78.9%+	77.1%+	73.8%+

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

▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

COA: Strengths

For the CHP+ population, COA scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 on one measure, *How Well Doctors Communicate*.

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

COA experienced no statistically significant decreases in FY 2019–2020 scores compared to the previous year. Two quality of care domain measures, *Customer Service* and *Rating of Specialist Seen Most Often*, exhibited a downward trend from FY 2017–2018 through FY 2019–2020. Performance for these measures may be related to a variety of factors, including whether members felt treated with courtesy and respect by office staff members and received the services they needed in a timely manner. HSAG recommends that the Department work with COA and explore what may be driving a decrease in the *Customer Service* and *Rating of Specialist Seen Most Often* scores from FY 2017–2018 to FY 2019–2020 and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

COA: Strengths

During FY 2019–2020, COA participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used COA's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports. Table 3-8 and Table 3-9 summarize HSAG's geoaccess analysis results by county classification for COA, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met across all counties in which COA's members resided, and the percentage of standards met across all counties in which COA's members resided. While no CHP+ plan met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the CHP+ plans are working to address.

Table 3-8—COA CHP+ MCO's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	33	23	69.7%	19	18	94.7%	19	19	100%
Primary Care Time/Distance	14	8	43.0%	25	6	52.9%	18	6	46.9%
Physical Health Time/Distance	14	23	23.4%	25	13	1.5%	18	13	9.0%
Behavioral Health Time/Distance	14	6	53.3%	25	3	68.0%	18	3	74.1%
Facilities Time/Distance	14	4	14.3%	25	4	15.0%	18	4	33.3%

Table 3-9—COA SMCN's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	33	32	97.0%	33	33	100%	33	33	100%
Primary Care Time/Distance	14	8	61.3%	27	8	63.3%	18	8	60.8%
Physical Health Time/Distance	14	23	38.4%	27	23	18.6%	18	23	33.2%
Behavioral Health Time/Distance	14	6	73.1%	27	6	71.8%	18	6	78.1%
Facilities Time/Distance	14	4	16.1%	27	4	16.7%	18	4	36.1%

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

COA's network included no practitioners attributed to the Pediatric Primary Care Provider (Mid-Level) network category. Consequently, COA failed to meet the time/distance network standards for the network category and standard. Failure to meet the urban access standards was largely attributable to the closest network locations being further than the required standard, compared to members' places of residence. Failure to meet the rural and frontier network category access standards was largely attributable to the nearest network locations being outside the required travel time or distance standards for COA's members residing in those counties.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for COA's data values for provider type, specialty, and credentials. As such, HSAG recommends that COA continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Denver Health Medical Plan, Inc.

Assessment of Compliance With CHIP Managed Care Regulations

Denver Health Medical Plan, Inc. (DHMP) Overall Evaluation

Table 3-10 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 2019–2020.

Table 3-10—Summary of DHMP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	36	32	31	1	0	4	97%
Standard II—Access and Availability	16	16	14	2	0	0	88%
Totals	**52**	**48**	**45**	**3**	**0**	**4**	**94%***

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

Table 3-11 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 2019–2020.

Table 3-11—Summary of DHMP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	53	44	9	37	83%
Totals	**90**	**53**	**44**	**9**	**37**	**83%***

**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's UM policies and procedures accurately addressed requirements for processing requests for authorization of services, including authorization criteria, clinical expertise of medical reviewers, consultation with the requesting provider, required time frames for providing notifications, and content of the NABD. DHMP's medical director or a subcontracted panel of physician specialists made all

denial decisions in records reviewed on-site. NABD template letters included all required content and were written in language easy for the member to understand. On-site denial record reviews also confirmed DHMP's compliance with all procedural requirements. Pharmacy authorization policies defined procedures for reviewing and authorizing pharmacy requests and notifying the provider and/or requestor of approval or denial of the request no later than 24 hours after receiving the request. HSAG observed that requests for authorization and notices to the member were time and date stamped to ensure that authorizations were processed within required time frames.

DHMP's emergency and post-stabilization policy accurately defined "emergency services," "emergency condition," and "post-stabilization," and addressed requirements for coverage and payment of emergency and post-stabilization services. Staff members confirmed that DHMP pays all emergency facility claims, regardless of circumstances. If a post-stabilization inpatient stay had not been previously authorized, claims were pended and forwarded to the UM department for UM authorization determination. For post-stabilization services delivered out of network, the Denver Health transfer team assisted the member with transfer to a DHMP network facility. DHMP confirmed that it does not balance bill members for any services delivered in or out of network.

The Denver Health and Hospital Authority (DHHA)-employed provider network was DHMP's primary source of practitioners to serve its CHP+ members. At the time of the site visit, DHMP had also recently contracted with a large primary care clinic network to provide improved access for DHMP's members. DHMP provided evidence of using numerous data sources to monitor adequacy of geographical access and timeliness of appointments for primary and non-urgent physical healthcare. DHMP's policies and procedures articulated processes for providing access to out-of-network providers for second opinions or due to inability to provide timely services in network. DHMP provided evidence of robust training on cultural competency, and used data collected on members' and providers' languages and ethnicity to determine the cultural competency and sufficiency of the network.

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

Standard I—Coverage and Authorization of Services

One of the two CHP+ NABD template letters included several inaccuracies in the detailed content of the appeal, State fair hearing (SFH), and continuation of benefits information, which resulted in deficient record review findings for "notice includes required content." DHMP was required to correct inaccuracies in the required content of the CHP+ NABD template.

Standard II—Access and Availability

Although DHMP provided evidence of monitoring timeliness of appointments in several required categories, DHMP was unable to provide evidence of tracking timeliness standards for behavioral healthcare, non-urgent symptomatic care within seven days, or an outpatient follow-up appointment within seven days. In addition, DHMP did not have a mechanism to monitor compliance with timely access standards for its externally contracted organizational providers. DHMP was required to:

- Develop a mechanism to track compliance with all timely access appointment standards.
- Develop a mechanism to monitor contracted providers to ensure compliance with timely access standards.

DHMP: Trended Performance for Compliance With Regulations

Table 3-12 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 3-12—Compliance With Regulations Trended Performance for DHMP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)*	**94%**	**97%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**92%**	**88%**
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 Systems (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 2019–2020.*

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

Trending scores over the past two review cycles indicate that DHMP improved its performance in three of the 10 standards: Standard I—Coverage and Authorization of Services, Standard VI—Grievance and Appeal Systems, and Standard VIII—Credentialing and Recredentialing, with a 10 percentage point increase in Standard VI—Grievance and Appeal Systems. In two standard areas, Standard IV—Member Rights and Protections and Standard VIII—Credentialing and Recredentialing, DHMP maintained consistently high performance at or near 100 percent. DHMP experienced slight declines in performance—less than 10 percentage points—in three standards, Standard II—Access and Availability, Standard V—Member Information, and Standard X—Quality Assessment and Performance, and experienced substantial performance 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. HSAG recommends that DHMP continue to focus on improving performance and compliance with federal and State managed care regulations for Standard III—Coordination and Continuity of Care and Standard VII—Provider Participation and Program Integrity.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the 2020 HEDIS Compliance Audit Report, DHMP 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 DHMP's HEDIS performance measure reporting.

Performance Measure Results

Table 3-13 shows the performance measure results for DHMP for HEDIS 2018 through HEDIS 2020, along with the percentile rankings for each HEDIS 2020 rate.

Table 3-13—Performance Measure Results for DHMP

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[2]				
Combination 2	BR	67.46%	82.26%^	≥90th
Combination 3	BR	65.87%	82.26%^	≥90th
Combination 4	BR	65.87%	82.26%^	≥90th
Combination 5	BR	57.94%	79.03%^	≥90th
Combination 6	BR	46.03%	59.68%	≥90th
Combination 7	BR	57.94%	79.03%^	≥90th
Combination 8	BR	46.03%	59.68%	≥90th
Combination 9	BR	41.27%	58.06%^	≥90th
Combination 10	BR	41.27%	58.06%^	≥90th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	68.81%	82.24%	86.71%	75th–89th
Combination 2 (Meningococcal, Tdap, HPV)	49.54%	55.92%	53.80%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	15.15%	2.22%^	25th–49th
Six or More Visits	NA	63.64%	66.67%	50th–74th
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	46.64%	64.74%	71.33%^	25th–49th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	37.64%	45.30%	52.41%^	25th–49th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[2]	17.71%	21.80%	23.81%	<10th
Counseling for Nutrition—Total	6.41%	7.93%	8.31%	<10th
Counseling for Physical Activity—Total	1.40%	6.65%	7.41%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	69.03%	90.36%	90.00%	<10th
Ages 25 Months to 6 Years	57.24%	73.58%	81.24%^	10th–24th
Ages 7 to 11 Years	81.33%	86.93%	84.85%	10th–24th
Ages 12 to 19 Years	78.05%	82.04%	82.08%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	39.74%	47.22%	47.89%	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				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[3]	—	—	NA	—
Cholesterol Testing—Total[3]	—	—	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[3]				
Ages 3 to 17 Years	—	—	90.58%	—
Appropriate Treatment for Upper Respiratory Infection[3]				
Ages 3 Months to 17 Years	—	—	97.88%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[3]				
Ages 3 Months to 17 Years	—	—	NA	—
Medication Management for People With Asthma[2]				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
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[2]				
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)				
*Emergency Department Visits**	18.43	21.49	22.57	≥90th
Outpatient Visits	123.51	135.56	158.85	<10th
Inpatient Utilization—General Hospital/Acute Care[2]				
Discharges per 1,000 Member Months (Total Inpatient)	0.69	0.82	1.05	<10th
Average Length of Stay (Total Inpatient)	4.25	3.07	2.59	<10th
Discharges per 1,000 Member Months (Medicine)	0.49	0.60	0.79	<10th
Average Length of Stay (Medicine)	2.90	2.59	2.30	<10th
Discharges per 1,000 Member Months (Surgery)	0.18	0.17	0.17	<10th
Average Length of Stay (Surgery)	8.07†	5.07†	3.90†	<10th
Discharges per 1,000 Member Months (Maternity)	0.02	0.09	0.16	<10th
Average Length of Stay (Maternity)	2.00†	2.00†	2.60†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.09	0.14	0.18	≥90th
Average Days Supplied per Antibiotic Script	12.07	11.28	10.88	<10th
Average Scripts PMPY for Antibiotics of Concern	0.02	0.03	0.04	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	23.31%	24.04%	23.74%	≥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 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure for 2019, NCQA recommends trending between 2019 and prior years be considered with caution.

[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 lower 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 statistically significant improvement in performance from the previous year.

DHMP: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS 2019):

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

For HEDIS 2020, DHMP showed strong performance with vaccinating children and adolescents by ranking above the 75th percentile for all 11 measure rates and above the 90th percentile for 10 of 11 (90.9 percent) measure rates. Further, seven of nine (77.8 percent) of the *Childhood Immunization Status* measure indicators demonstrated a significant increase from the previous year. Additionally, the MCO continued to demonstrate strength ensuring providers are 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 2020 measure rates were determined to be low performers for DHMP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS 2019):

- *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 four of 11 (35.4 percent) measure rates determined to be low performers for HEDIS 2020, DHMP continued to demonstrate opportunities to improve access to preventive care and services for children and adolescents. DHMP fell below the 25th percentile for all four indicators under the *Children and Adolescents' Access to Primary Care Practitioners* measure. DHMP also fell below the 10th percentile for *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*. 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*.[3-1]

Validation of Performance Improvement Projects

Table 3-14 and Table 3-15 display the FY 2019–2020 validation findings for DHMP's *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP. During FY 2019–2020, DHMP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by DHMP are summarized in Table 3-14.

Table 3-14—Intervention Determination Summary for the *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Member does not show up for the scheduled appointment	• Education and communication to members about the importance of an adolescent well-care (AWC) visit • Communication regarding free transportation to appointment options – Potential intervention methods to be tested include: o Enlisting Webb Pediatrics patient navigators or the plan's Ambulatory Care Services (ACS) central patient navigators to call the parents/guardians of members with birthdays in the next calendar month who have not had a well-child visit in over a year to remind them of the importance of an AWC and inform them of available free transportation services and tracking resulting appointments through Epic and/or the claims database o Sending mobile text messages to parents/guardians of members who are not current on their AWC to educate them on the importance of an AWC visit, how to schedule, and how to receive free transportation and track resulting appointments through Epic and/or the claims database o Creating a script for Webb Pediatrics Clinic staff members to follow when making reminder calls for scheduled appointments that will include information regarding the importance of attending an AWC appointment and questions and answers regarding free transportation options to the appointment with clinic staff members documenting both calls and results • Decisions regarding interventions will be made in consultation with Webb Pediatrics Clinic staff members, ACS analytics staff members, and through small feasibility tests

[3-1] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Sept 14, 2020.

Failure Modes	Potential Interventions
Clinic is not offering convenient appointment times (after school/work or weekends)	• When parent/guardian of member calls the appointment center, educate them about the option of scheduling an AWC visit at a school-based health center (SBHC). At Webb Pediatrics clinic and through DHMP, provide outreach and education about SBHCs including sharing with the parent/guardian the consent form for a member to be seen at an SBHC. • Allow for scheduling of AWC appointments via the Appointment Center 60 days out instead of the current 30-day scheduling limit.
Clinic staff members are unable to reach parent/guardian via phone call to confirm appointment	Send e-notifications through Denver Health's Epic MyChart—a software application connected to the member's Denver Health electronic medical record that allows the member to access medical information, schedule appointments, and communicate with providers—or mobile SMS text messages to parents/guardians of members with upcoming appointments

DHMP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-15 summarizes the intervention DHMP selected for testing.

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

Intervention Description	Key Drivers	Failure Mode
Education and communication to members about the importance of AWC visits and free transportation to appointment options	• Member compliance with well-care visits • Transportation to visits	Member does not show up for the scheduled appointment

DHMP: Strengths

DHMP continued work on a PIP focused on increasing the rate of adolescent well-care visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain an adolescent well-care visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive an adolescent well-care visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing its intervention through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, DHMP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

Findings

Table 3-16 shows the results achieved by DHMP for FY 2017–2018 through FY 2019–2020.

Table 3-16—Top-Box Scores for DHMP

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	83.5%	79.7%	80.5%
Getting Care Quickly	88.4%	85.0%	85.9%
How Well Doctors Communicate	95.6%	94.4%	96.9%
Customer Service	84.4%	87.8%	86.1%+
Rating of Health Plan	65.3%	65.4%	65.0%
Rating of All Health Care	70.2%	69.2%	66.5%
Rating of Personal Doctor	84.6%	75.7%	85.1% ▲
Rating of Specialist Seen Most Often	84.1%+	85.3%+	77.1%+

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.

▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

DHMP: Strengths

For the CHP+ population, DHMP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 on one measure, *Rating of Personal Doctor*.

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

DHMP experienced no statistically significant decreases in FY 2019–2020 scores compared to the previous year. One quality of care domain measure, *Rating of All Health Care*, exhibited a downward trend from FY 2017–2018 through FY 2019–2020. Performance of this measure may be related to whether members felt their health plan provided the care and services they needed. HSAG recommends that DHMP explore what may be driving a decrease in the score for this measure from FY 2017–2018 to FY 2019–2020 and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

DHMP: Strengths

During FY 2019–2020, DHMP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used DHMP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports. Table 3-17 summarizes HSAG's geoaccess analysis results by county classification for DHMP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met across all counties in which DHMP's members resided, and the percentage of standards met across all counties in which DHMP's members resided. While no CHP+ plan met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the CHP+ plans are working to address.

Table 3-17—DHMP's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	19	18	94.7%	18	17	94.4%	NA	NA	NA
Primary Care Time/Distance	9	6	54.0%	1	4	0.0%	NA	NA	NA
Physical Health Time/Distance	9	13	44.4%	1	13	0.0%	NA	NA	NA
Behavioral Health Time/Distance	9	3	25.9%	1	3	0.0%	NA	NA	NA
Facilities Time/Distance	9	4	25.0%	1	4	25.0%	NA	NA	NA

NA indicates that no standards are applicable to the county and network categories for the MCO; therefore, the percentage of standards met was not calculated.

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

DHMP's network data included no practitioners, practice sites, or entities for the Pediatric Substance Use Disorder Provider, Psychiatric Hospitals, Psychiatric Units in Acute Care Hospitals, or the Psychiatric Residential Treatment Facilities network categories. Consequently, DHMP failed to meet the time/distance network standards for those network categories and standards. Failure to meet the urban network category access standard was largely attributable to the closest network locations being outside the required travel time or distance standards for members residing in urban counties. Failure to meet the

rural network category access standards was attributable to the closest network locations being outside the required travel time or distance standard for the sole member residing in Delta County.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for DHMP's data values for provider type, specialty, and credentials. As such, HSAG recommends that DHMP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Friday Health Plans of Colorado

Assessment of Compliance With CHIP Managed Care Regulations

Friday Health Plans of Colorado (FHP) Overall Evaluation

Table 3-18 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2019–2020.

Table 3-18—Summary of FHP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	36	32	20	6	6	4	63%
Standard II—Access and Availability	16	16	13	3	0	0	81%
Totals	**52**	**48**	**33**	**9**	**6**	**4**	**69%***

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

Table 3-19 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 2019–2020.

Table 3-19—Summary of FHP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	52	39	13	38	75%
Totals	**90**	**52**	**39**	**13**	**38**	**75%***

**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's policies and procedures and on-site interviews confirmed that systems were in place for review and authorization of initial and continuing services, which addressed multiple authorization requirements and accurately outlined the time frames for standard, expedited, and concurrent review decisions. Denial record reviews demonstrated compliance with required time frames and written

notification to the member. Policies documented processes for utilizing multidisciplinary medical peer reviewers qualified to render a clinical opinion about services being reviewed for authorization and FHP offered a peer-to-peer consultation with the requesting service provider prior to making a denial decision. The NABD template was available in English and Spanish and was written in language reasonably easy for the member to understand.

FHP's medical management procedures and CHP+ member handbook accurately defined "emergency medical condition," "emergency services," and "post-stabilization services." FHP confirmed that it does not require prior authorization for emergency services in or out of network. FHP's staff members reported that FHP's claims system auto-approves a number of pre-defined emergent conditions and that all other emergency service claims are reviewed and approved by the UM Nurse Manager and Medical Director applying the prudent layperson standard for determining an emergency medical condition. Staff members stated that Milliman Care Guidelines include criteria for post-stabilization services that are applied to determine medical necessity of post-stabilization services.

FHP demonstrated having an active process for analysis and oversight of network adequacy, including review of geoaccess maps, service utilization data, census data, recent claims, customer services statistics, and key performance indicators. FHP utilized various assessment tools to evaluate network access standards, including quarterly sampling of network providers to determine compliance with scheduling standards; a provider office site quality checklist to evaluate physical accessibility, equipment accessibility, and Americans with Disabilities Act (ADA) compliance; and a provider network disruption analysis to pinpoint any disruptions to access that occurred and required follow up. FHP utilized single case agreements in instances when the provider network was unable to deliver necessary covered services and out-of-network services were necessary. FHP maintained written policies related to cultural competency and maintained a list of resources where providers could obtain additional cultural competency training, continuing education, and other beneficial documents for providing culturally sensitive care.

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

Standard I—Coverage and Authorization of Services

The CHP+ "desktop procedures (DTP)" regarding expedited authorization time frames inaccurately stated the time frame for expedited authorization decisions as within three business days of receipt. FHP was required to correct its DTPs and any related documents to include accurate time frames for making expedited authorization decisions (72 hours) and for notifying the member.

Through on-site denial record reviews, HSAG found that FHP's NABD included no taglines and the information entered into the NABD regarding the reason for denial was not easy for the member to understand. FHP was required to:

- Include taglines in its NABD informing the member of the availability of the notice in alternative formats.
- Ensure that all information in the NABD is written in language easy for the member to understand.

FHP's NABD included numerous omissions or inaccuracies in the required content of the notice including outdated regulatory information concerning time frames for filing appeals or a SFH, failure to describe the member's right to request a SFH *only* after receiving an adverse appeal resolution notice from FHP, omitting *how* to request that benefits continue during an appeal, offering a reconsideration process prior to an appeal (i.e., two levels of appeal), and omitting the member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. FHP was required to revise the content of the NABD to include all required content and accurate appeals information, per updated CHP+ federal and State regulations.

FHP had no operating procedures that addressed the member notification time frames for termination, suspension, or reduction of previously authorized services (or exceptions to this time frame); extended service authorization time frames; or authorizations not reached within the required time frames. FHP was required to develop or enhance CHP+ operating procedures to address all required time frames for mailing the NABD.

FHP's emergency and urgent care services DTP did not address mechanisms for authorizing payment for emergency services "when a representative of FHP instructed the member to seek emergency services." FHP was required to enhance procedures related to payment for emergency service claims to address this requirement.

FHP had no written operating procedures to guide staff members in the review of post-stabilization services regarding the criteria for determining financial responsibility outlined in 42 CFR §422.113(c). FHP was required to develop internal operating procedures regarding FHP's financial responsibility for payment of post-stabilization services, including:

- Services that are prior authorized, whether provided in or out of network.
- Services that are not pre-approved but administered within one hour of request for approval.
- Services that are not pre-approved but the organization does not respond to request for approval, cannot be contacted, or when the treating physician and FHP cannot reach agreement.
- When financial responsibility for post-stabilization care that is not pre-approved ends.
- Member liability for payment of post-stabilization services received out of network as defined in 42 CFR §422.113(c)(3).

Neither FHP's policies and procedures nor FHP's delegated pharmacy benefit manager (PBM) procedures accurately addressed requirements for providing 24-hour notice to the requestor of authorization determinations regarding covered outpatient drugs. FHP was required to:

- Ensure that its PBM has accurate policies and procedures regarding the time frame for providing notice of authorization for covered outpatient drugs.
- Ensure that its PBM complies with the requirement to provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor for making the authorization decision.

- Develop or enhance FHP policies and procedures to address review and notification of authorization for covered outpatient drugs.

Standard II—Access and Availability

FHP did not include in its timely access to care standards: emergency behavioral healthcare by phone or in person, ensuring that members are not placed on waiting lists for initial routine behavioral health services, and outpatient follow-up appointments within seven days after discharge. Similarly, FHP did not have a mechanism to monitor providers for compliance with these three missing standards. FHP was required to:

- Expand its standards for timely access to include all standards defined by the State.
- Expand mechanisms for monitoring providers for compliance with these additional standards for timely access.

FHP did not have a written procedure outlining the entire process for ensuring timely access standards are met. FHP was required to develop a written procedure that outlines a monitoring process that addresses mechanism for monitoring, frequency of monitoring, and taking corrective action.

FHP had no established method by which health plan staff members were provided with cultural competency training programs. FHP was required to develop and implement mechanisms to provide staff members training programs regarding cultural factors affecting access to care or medical risks.

FHP: Trended Performance for Compliance With Regulations

Table 3-20 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 3-20—Compliance With Regulations Trended Performance for FHP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)*	**91%**	**63%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**79%**	**81%**
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 Systems (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 and Applicable Review Years	Previous Review	Most Recent Review
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	73%	83%

**Bold text indicates standards reviewed by HSAG during FY 2019–2020.*

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

Trending scores over the past two review cycles indicate that FHP improved performance in eight of the 10 standards, with the greatest improvement (55 percentage points) observed in Standard VI—Grievance and Appeal Systems and substantial improvements in Standard III—Coordination and Continuity of Care (28 percentage points), Standard V—Member Information (18 percentage points), and Standard VII—Provider Participation and Program Integrity (24 percentage points). FHP also demonstrated improvement of 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. In the FY 2019–2020 review cycle, FHP's performance declined substantially (28 percentage points) in Standard I—Coverage and Authorization of Services compared to the previous review. 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 recommends that FHP evaluate its systems and processes to renew efforts to achieve high performance in complying with federal and State managed care regulations for Standard I—Coverage and Authorization of Services.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the 2020 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 3-21 shows the performance measure results for FHP for HEDIS 2018 through HEDIS 2020, along with the percentile rankings for each HEDIS 2020 rate.

Table 3-21—Performance Measure Results for FHP

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[2]				
Combination 2	7.84%	4.76%	0.00%	<10th
Combination 3	5.88%	4.76%	0.00%	<10th
Combination 4	3.92%	4.76%	0.00%	<10th
Combination 5	0.00%	4.76%	0.00%	<10th
Combination 6	3.92%	0.00%	0.00%	<10th
Combination 7	0.00%	4.76%	0.00%	<10th
Combination 8	1.96%	0.00%	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)	15.94%	26.32%	41.94%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	5.80%	12.28%	8.06%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	NA	NA	—
Six or More Visits	NA	NA	NA	—
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	43.72%	55.62%	**27.27%^^**	<10th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	25.05%	37.65%	**8.17%^^**	<10th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[2]	1.69%	9.70%	13.69%	<10th
Counseling for Nutrition—Total	5.92%	4.65%	5.38%	<10th
Counseling for Physical Activity—Total	3.38%	6.26%	**1.96%^^**	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	NA	NA	NA	—
Ages 25 Months to 6 Years	65.33%	71.90%	67.27%	<10th
Ages 7 to 11 Years	73.58%	87.18%	81.94%	<10th
Ages 12 to 19 Years	80.49%	86.43%	83.17%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	13.95%	NA	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				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[3]	—	—	NA	—
Cholesterol Testing—Total[3]	—	—	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[3]				
Ages 3 to 17 Years	—	—	65.81%	—
Appropriate Treatment for Upper Respiratory Infection[3]				
Ages 3 Months to 17 Years	—	—	91.67%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[3]				
Ages 3 Months to 17 Years	—	—	NA	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Medication Management for People With Asthma[2]				
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[2]				
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)				
*Emergency Department Visits**	15.98	17.33	20.17	≥90th
Outpatient Visits	175.38	166.81	190.96	<10th
Inpatient Utilization—General Hospital/Acute Care[2]				
Discharges per 1,000 Member Months (Total Inpatient)	0.65	0.37	0.32	<10th
Average Length of Stay (Total Inpatient)	2.13†	2.33†	1.71†	<10th
Discharges per 1,000 Member Months (Medicine)	0.45	0.21	0.37	<10th
Average Length of Stay (Medicine)	2.36†	2.00†	1.60†	<10th
Discharges per 1,000 Member Months (Surgery)	0.16	0.17	0.09	<10th
Average Length of Stay (Surgery)	1.50†	1.50†	2.00†	<10th
Discharges per 1,000 Member Months (Maternity)	0.08	0.00	0.00	<10th
Average Length of Stay (Maternity)	2.00†	NA	NA	—
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.97	12.00	0.42	≥90th
Average Days Supplied per Antibiotic Script	16.68	99.95	102.83	<10th
Average Scripts PMPY for Antibiotics of Concern	0.41	2.32	0.15	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	41.62%	19.35%	35.97%	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 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure for 2019, NCQA recommends trending between 2019 and prior years be considered with caution.

[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 lower 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 red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

FHP: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for FHP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS 2019):

- *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.

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

The following HEDIS 2020 measure rates were determined to be low performers for FHP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS 2019):

- *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, Ages 7 to 11 Years,* and *Ages 12 to 19 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 25th 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 2020, 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.

Validation of Performance Improvement Projects

Table 3-22 and Table 3-23 display the FY 2019–2020 validation findings for FHP's *Well-Child Visits in the 6th Through 14th Years of Life* PIP. During FY 2019–2020, FHP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by FHP are summarized in Table 3-22.

Table 3-22—Intervention Determination Summary for the *Well-Child Visits in the 6th Through 14th Years of Life* PIP

Failure Modes	Potential Interventions
Provider does not outreach to members and parents/guardians to schedule a well visit appointment	Develop a continuous communication plan with San Luis Valley Health (SLVH) to ensure that the report identifying members due for well visits is received
Member does not attend scheduled well visit appointment	Member outreach and follow-up to reconnect with members and parents/guardians after a missed appointment; upon follow-up contact, FHP will identify the members' barriers to attending the appointment and attempt to address the barriers
FHP is unable to reach the member's parent/guardian to notify parent/guardian that the member is due for a well visit, educate on importance of well visits	Multi-pronged outreach to parents/guardians of members due for a well visit, to include multiple phone calls, a mailed letter, and personalized web portal
Provider does not generate and share with FHP a report of members who are due for a well visit	FHP will manually sort through the health plan's internal report to determine which members see an SLVH provider, rather than relying on the provider to report to the health plan

FHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-23 summarizes the intervention FHP selected for testing.

Table 3-23—Planned Intervention for the *Well-Child Visits in the 6th Through 14th Years of Life* PIP

Intervention Description	Key Driver	Failure Modes
Working with the narrowed focus provider to identify members due for well visits and conducting member outreach phone calls to provide education and schedule well visit appointments	*Not reported by the health plan*	• Provider does not generate a report to identify members who are due for a well visit • Provider does not outreach to members to schedule a well visit appointment

FHP: Strengths

FHP continued work on a PIP focused on increasing the rate of well-child visits among members 6 to 14 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing its intervention through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, FHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

Findings

Table 3-24 shows the results achieved by FHP for FY 2017–2018 through FY 2019–2020.

Table 3-24—Top-Box Scores for FHP

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	86.1%	90.1%+	81.9%+
Getting Care Quickly	89.9%	91.0%+	94.1%+
How Well Doctors Communicate	95.3%	92.9%	99.0%+ ▲
Customer Service	82.0%+	84.0%+	97.5%+ ▲
Rating of Health Plan	47.4%	55.2%	59.1%
Rating of All Health Care	52.2%	50.6%	59.8%+
Rating of Personal Doctor	62.3%	71.0%	74.5%
Rating of Specialist Seen Most Often	67.6%+	71.1%+	77.8%+

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

▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

FHP: Strengths

For the CHP+ population, FHP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 on two measures: *How Well Doctors Communicate* and *Customer Service*.

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

FHP experienced no statistically significant decreases in FY 2019–2020 scores compared to the previous year. Only one measure, *Getting Needed Care*, showed a decrease in the FY 2019–2020 score compared to the FY 2018–2019 score. HSAG recommends that FHP explore what may be driving a decrease in the score for this measure from FY 2017–2018 to FY 2019–2020 and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

FHP: Strengths

During FY 2019–2020, FHP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used FHP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports. Table 3-25 summarizes HSAG's geoaccess analysis results by county classification for FHP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met across all counties in which FHP's members resided, and the percentage of standards met across all counties in which FHP's members resided. While no CHP+ plan met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the CHP+ plans are working to address.

Table 3-25—FHP's Provider Ratio and Time/Distance Results by County Classification

	Urban			Rural			Frontier		
Measure Results	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	18	18	100%	19	19	100%	19	19	100%
Primary Care Time/Distance	2	4	75.0%	12	6	57.8%	13	6	54.1%
Physical Health Time/Distance	2	13	46.2%	12	13	4.5%	13	13	21.3%
Behavioral Health Time/Distance	2	3	33.3%	12	3	36.1%	13	3	38.5%
Facilities Time/Distance	2	4	37.5%	12	4	25.0%	13	4	46.2%

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

FHP's network data included no practitioners, practice sites, or entities for the following network categories: Pediatric Primary Care Provider (Mid-Level), Psychiatric Hospitals, Psychiatric Units in Acute Care Hospitals, or Psychiatric Residential Treatment Facilities. Consequently, FHP failed to meet the time/distance network standards for those network categories and standards. Failure to meet the urban network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for members residing in urban counties. Failure to meet the rural network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for the limited number of members

residing in rural counties (i.e., fewer than five members). Failure to meet the frontier network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for FHP's members (i.e., fewer than 50 members).

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for FHP's data values for provider type, specialty, and credentials. As such, HSAG recommends that FHP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Kaiser Permanente Colorado

Assessment of Compliance With CHIP Managed Care Regulations

Kaiser Permanente Colorado (Kaiser) Overall Evaluation

Table 3-26 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 2019–2020.

Table 3-26—Summary of Kaiser Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	36	31	21	5	5	5	68%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**47**	**37**	**5**	**5**	**5**	**79%***

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

Table 3-27 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 2019–2020.

Table 3-27—Summary of Kaiser Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	61	40	21	29	66%
Totals	**90**	**61**	**40**	**21**	**29**	**66%***

**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

Kaiser's policies and procedures and on-site review demonstrated an effective operational infrastructure to support coverage and authorization of services for CHP+ members. UM physicians and a team of specialty physician consultants provided appropriate clinical expertise for making final UM determinations. Kaiser notified members and providers in writing of any denial of authorization

decisions within the required time frames and attached appeal rights and processes to each NABD. The UM policy and on-site interviews confirmed that Kaiser does not terminate, suspend, or reduce previously authorized services. On-site record reviews demonstrated that Kaiser date and time-stamped receipt of authorization requests and notices mailed to members.

Kaiser does not require prior authorization for emergency services and auto-pays all emergency service claims, whether services were delivered in or out of network. Staff members stated that post-stabilization services—such as inpatient hospitalization—require authorization for medical necessity. Kaiser demonstrated a process for pending post-stabilization claims without an authorization and forwarding the case to the UM staff for a medical necessity determination and a final claim adjudication decision.

Kaiser demonstrated mechanisms for maintaining and monitoring access to providers, including comprehensive analysis of its provider network through identification of high-volume specialties, analyzing geographic distribution of members and providers, calculating member-to-provider ratios, assessing sufficiency of facility types, and conducting a barrier analysis upon notification of a new or impending change in the provider network. Kaiser also offered convenient and alternative modes of care to members, such as video visit, e-visit, or telephonic visit. Kaiser facilities offered physical accommodations to ensure sufficient member accessibility to members with physical or mental disabilities. Kaiser allowed service animals to accompany members and provided auxiliary aids and services free of charge, including mobility equipment and devices. Language accommodations included video remote interpretive services, phone translators, and in-person translators, and Kaiser's online provider directory informed members which providers or offices had staff members proficient in specific languages. Kaiser published CHP+ timely access standards to providers and members and monitored compliance through a variety of reporting mechanisms. Kaiser providers were trained in cultural competency, and Kaiser's internal clinical library offered providers and staff cultural competency continuing education options, as well as cultural and ethnic-specific clinical guidance, clinical tools, and member handouts.

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

Standard I—Coverage and Authorization of Services

Although Kaiser's authorization policies articulated mechanisms for consulting with the requesting provider to obtain additional information when making an authorization decision, on-site denial record reviews identified a circumstance in which Kaiser requested additional clinical information from the member's family but not from the requesting provider. Kaiser was required to ensure that reviewers consult with the requesting provider to obtain additional information to make an authorization decision.

Kaiser's timelines for making a UM decision policy included an inaccurate time frame for making expedited authorization decisions. Kaiser was required to correct its policies and procedures to reflect the 72-hour time frame for making expedited decisions.

Kaiser did not provide a written policy or procedure addressing the requirement to authorize outpatient drug requests within 24 hours. In addition, a timelines grid used to provide guidance to pharmacy staff members inaccurately specified the time frame for responding to requests for outpatient drug authorization. Kaiser was required to develop a written policy and to implement procedures to provide telephonic or telecommunication notice of the authorization decision within 24 hours of receipt of complete information from the prescriber/requestor.

Kaiser's NABD template language included numerous terms beyond the sixth-grade reading level, including clinical jargon and Kaiser's rule and regulation information. The appeals information in the NABD included continuation of benefits information when not applicable to the type of denial. In addition, the appeals information in the NABD included several inaccuracies in current regulatory time frames and processes. HSAG found via denial record reviews that Kaiser failed to meet the requirements "correspondence with the member was easy to understand" and "NABD includes required content." Kaiser was required to:

- Simplify the content and language in the NABD to comply with CHP+ sixth-grade reading requirements.
- Update the NABD appeals information to correct inaccuracies in appeal and SFH time frames and processes.

Although Kaiser applied established medical necessity criteria to make authorization decisions for post-stabilization services, Kaiser did not have internal processes or written procedures for application of the regulatory guidelines in determining financial responsibility for post-stabilization care services that are not pre-approved, including all requirements related to financial responsibility for payment outlined in 42 CFR §422.113(c). Kaiser was required to develop and implement internal procedures to determine financial responsibility of the contractor for post-stabilization care services that have not been pre-approved.

Kaiser: Trended Performance for Compliance With Regulations

Table 3-28 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 3-28—Compliance With Regulations Trended Performance for Kaiser

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)*	**94%**	**68%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**93%**	**100%**
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 and Applicable Review Years	Previous Review	Most Recent Review
Standard VI—Grievance and Appeal Systems (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 2019–2020.*

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

Trending scores over the past two review cycles 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 (less than 10 percentage points) in three additional standards: Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, and Standard VI—Grievance and Appeal Systems. Kaiser either maintained or improved to 100 percent compliance in three standards: Standard II—Access and Availability, Standard V—Member Information, and Standard VIII—Credentialing and Recredentialing. Kaiser maintained consistent compliance (variance of 2 percentage points or less) in Standard VII—Provider Participation and Program Integrity. Although Kaiser demonstrated slight improvement in Standard VI—Grievance and Appeal Systems, results remained consistently low (from 65 percentage points to 68 percentage points) over the two review periods. In addition, in FY 2019–2020, Kaiser's performance in Standard I—Coverage and Authorization of Services substantially declined (26 percentage points) compared to the previous review. 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. HSAG recommends that Kaiser continue to focus on improving performance in compliance with federal and State managed care regulations with particular attention to Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the 2020 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 HEDIS performance measure reporting.

Performance Measure Results

Table 3-29 shows the performance measure results for Kaiser for HEDIS 2018 through HEDIS 2020, along with the percentile rankings for each HEDIS 2020 rate.

Table 3-29—Performance Measure Results for Kaiser

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[2]				
Combination 2	70.85%	69.46%	75.94%	50th–74th
Combination 3	70.17%	67.36%	74.33%	50th–74th
Combination 4	69.15%	66.95%	74.33%	75th–89th
Combination 5	62.03%	62.76%	69.52%	≥90th
Combination 6	43.73%	41.84%	59.89%^	≥90th
Combination 7	61.02%	62.34%	69.52%	≥90th
Combination 8	43.39%	41.84%	59.89%^	≥90th
Combination 9	39.32%	40.59%	56.15%^	≥90th
Combination 10	38.98%	40.59%	56.15%^	≥90th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	82.30%	82.84%	82.33%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	53.98%	56.44%	53.67%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	2.91%	2.02%	1.69%	25th–49th
Six or More Visits	66.02%	73.74%	76.27%	≥90th
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	59.35%	65.44%	65.50%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	41.18%	45.24%	46.58%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
BMI Percentile Documentation—Total[2]	97.29%	98.57%	98.04%	≥90th
Counseling for Nutrition—Total	95.57%	96.18%	95.14%	≥90th
Counseling for Physical Activity—Total	95.57%	96.18%	95.14%	≥90th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	87.44%	97.22%	**91.30%^^**	10th–24th
Ages 25 Months to 6 Years	75.76%	83.25%	83.89%	10th–24th
Ages 7 to 11 Years	86.56%	86.81%	89.45%	25th–49th
Ages 12 to 19 Years	88.45%	88.26%	87.70%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	41.43%	45.51%	52.69%	25th–49th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.00%	0.25%	≥90th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	45.16%	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[3]	—	—	NA	—
Cholesterol Testing—Total[3]	—	—	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[3]				
Ages 3 to 17 Years	—	—	92.39%	—
Appropriate Treatment for Upper Respiratory Infection[3]				
Ages 3 Months to 17 Years	—	—	97.51%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[3]				
Ages 3 Months to 17 Years	—	—	93.33%	—
Medication Management for People With Asthma[2]				
Medication Compliance 50%—Ages 5 to 11 Years	46.67%	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Medication Compliance 75%—Ages 5 to 11 Years	23.33%	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio[2]				
Ages 5 to 11 Years	93.33%	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	11.54	18.86	21.93	≥90th
Outpatient Visits	151.08	133.57	158.31	<10th
Inpatient Utilization—General Hospital/Acute Care[2]				
Discharges per 1,000 Member Months (Total Inpatient)	0.62	0.49	0.69	<10th
Average Length of Stay (Total Inpatient)	3.51	3.67	4.86	75th–89th
Discharges per 1,000 Member Months (Medicine)	0.46	0.40	0.46	<10th
Average Length of Stay (Medicine)	3.34	2.29	3.35	10th–24th
Discharges per 1,000 Member Months (Surgery)	0.12	0.08	0.22	<10th
Average Length of Stay (Surgery)	4.24†	10.50†	8.17†	<10th
Discharges per 1,000 Member Months (Maternity)	0.07	0.01	0.02	<10th
Average Length of Stay (Maternity)	3.20†	3.00†	3.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.26	0.19	0.29	≥90th
Average Days Supplied per Antibiotic Script	12.15	12.47	11.52	<10th
Average Scripts PMPY for Antibiotics of Concern	0.05	0.05	0.08	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	19.57%	24.21%	27.59%	≥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 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure for 2019, NCQA recommends trending between 2019 and prior years be considered with caution.

[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 lower 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 statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Kaiser: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for Kaiser (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS 2019):

- *Childhood Immunization Status—Combinations 4–10*
- *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*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

For HEDIS 2020, Kaiser demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for all 11 measure rates and exceeding the 90th percentile for seven of 11 (63.6 percent) measure rates. Further, four of seven (57.1 percent) measure rates that exceeded the 90th percentile demonstrated a significant improvement from the previous year. Additionally, the MCO continued to demonstrate strong rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, which exceeded the 90th percentile and continued to ensure 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 2020 measure rates were determined to be low performers for Kaiser (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS 2019):

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*

Despite demonstrating improvement for seven of eight (87.5 percent) measure rates determined to be low performers for HEDIS 2019, Kaiser demonstrated opportunities to improve the access to appropriate providers and services for members, as evidenced by the following measure rates falling below the 50th percentile: *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*; *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*; 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 3-30 and Table 3-31 display the FY 2019–2020 validation findings for Kaiser's *Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age* PIP. During FY 2019–2020, Kaiser completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by Kaiser are summarized in Table 3-30.

Table 3-30—Intervention Determination Summary for the *Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Kaiser does not send member a "you are due for a well visit" reminder at an appropriate time	Pilot having the local pediatric care team place outreach calls to parents/members who are approaching the due date for their recommended well visit
Member has not signed up to receive reminders of upcoming appointments via kp.org or text message	Pilot having the local pediatric care team, or a community specialist, make reminder calls or send reminder text messages 1–5 days before the scheduled appointment
Parent/member decides not to schedule (cost is too high/benefit is too low)	Pilot outreach calls during which a community specialist attempts to understand the reasons a parent/member decides not to schedule a well-visit and offers education and/or troubleshooting assistance

Kaiser also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-31 summarizes the intervention Kaiser selected for testing.

Table 3-31—Planned Intervention for the *Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Outreach calls prior to adolescent well care (AWC) visit due	*Not reported in Module 4*	Kaiser does not send member a "you are due for a well visit" reminder at an appropriate time

Kaiser: Strengths

Kaiser continued work on a PIP focused on increasing the rate of well-child visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to

obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing its intervention through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, Kaiser had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

Findings

Table 3-32 shows the results achieved by Kaiser for FY 2017–2018 through FY 2019–2020.

Table 3-32—Top-Box Scores for Kaiser

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	84.5%	85.5%	83.6%
Getting Care Quickly	88.8%	90.8%	86.4%
How Well Doctors Communicate	95.7%	97.8%	96.3%
Customer Service	86.0%	86.5%	89.3%+
Rating of Health Plan	61.1%	60.9%	61.8%
Rating of All Health Care	68.1%	67.2%	71.3%
Rating of Personal Doctor	74.5%	78.1%	78.1%
Rating of Specialist Seen Most Often	75.7%+	73.3%+	62.5%+

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, HSAG found no statistically significant increases in FY 2019–2020 CAHPS scores compared to the previous year.

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

Kaiser experienced no statistically significant decreases in FY 2019–2020 scores compared to FY 2018–2019. One quality of care domain measure, *Rating of Specialist Seen Most Often*, exhibited a downward trend from FY 2017–2018 through FY 2019–2020. Performance for this measure may be related to a variety of factors, including whether members felt they got an appointment for their child to see a specialist as soon as they needed. HSAG recommends that Kaiser explore what may be driving a decrease in the score for this measure from FY 2017–2018 to FY 2019–2020 and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

Kaiser: Strengths

During FY 2019–2020, Kaiser participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used Kaiser's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports. Table 3-33 summarizes HSAG's geoaccess analysis results by county classification for Kaiser, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met across all counties in which Kaiser's members resided, and the percentage of standards met across all counties in which Kaiser's members resided. While no CHP+ plan met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the CHP+ plans are working to address.

Table 3-33—Kaiser's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	33	32	97.0%	18	18	100%	18	18	100%
Primary Care Time/Distance	10	8	50.0%	3	4	25.0%	1	4	0.0%
Physical Health Time/Distance	10	23	47.1%	3	13	25.6%	1	13	0.0%
Behavioral Health Time/Distance	10	6	45.5%	3	3	55.6%	1	3	0.0%
Facilities Time/Distance	10	4	15.0%	3	4	8.3%	1	4	0.0%

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

Kaiser's network data included no practitioners, practice sites, or entities for the Pediatric Primary Care Provider (Mid-Level) network category. Consequently, Kaiser failed to meet the time/distance network standards for this network category and standard. Failure to meet the urban network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for members residing in urban counties. Failure to meet the rural network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for the sole member residing in each county. Kaiser did not meet any of

the network standards in the sole frontier county; however, standards were limited to calculations among two members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for Kaiser's data values for provider type, specialty, and credentials. As such, HSAG recommends that Kaiser continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Rocky Mountain Health Plans

Assessment of Compliance With CHIP Managed Care Regulations

Rocky Mountain Health Plans (RMHP) Overall Evaluation

Table 3-34 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 2019–2020.

Table 3-34—Summary of RMHP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	36	32	29	3	0	4	91%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**48**	**45**	**3**	**0**	**4**	**94%***

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

Table 3-35 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 2019–2020.

Table 3-35—Summary of RMHP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	62	60	2	28	97%
Totals	**90**	**62**	**60**	**2**	**28**	**97%***

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

RMHP: Strengths

RMHP submitted a large body of evidence demonstrating a thorough and comprehensive approach for the review, authorization, and denial of CHP+ covered services. In addition to RMHP's UM functions, RMHP delegated UM for specialized services to two different delegated entities and maintained detailed oversight of the delegated entities' performance in meeting the standards and requirements of the

delegation agreements. On-site record reviews demonstrated that NABDs to members and providers included required content related to the reason for the decision, the member's right to appeal and to request a SFH, and the possibility of requesting continued service/benefits pending the resolution of the appeal. Through on-site record review, HSAG found that, in addition to mailing members the NABD, RMHP staff members placed a call to each member to ensure that the decision was clearly understood and answer any questions.

RMHP's policies and procedures and member communications accurately defined "emergency condition," "emergency services," and "post-stabilization services," and explained that both emergency care and post-stabilization care services are covered and do not require a prior authorization. All emergency and urgent care services were payable at the claim processing level without review for medical necessity.

RMHP submitted a large body of evidence, which indicated that RMHP maintained a network of providers sufficient to cover services to its CHP+ members. RMHP's Network Capacity Report documented that primary care and specialist provider types met network adequacy time and distance standards in most areas, although RMHP experienced challenges with specialist access in some rural and frontier counties where additional providers do not exist. RMHP has implemented the use of telemedicine to address specific provider network inadequacies. RMHP provided evidence that a sufficient ratio of family planning providers were available to members and that out-of-network providers were made available to members when there was no qualified in-network provider. RMHP's policies and provider manual outlined the State's standards for timely access, and RMHP evaluated timely access by administering a member survey annually. RMHP provided a robust array of policies on cultural competency. RMHP discussed its provider education series, which addressed diverse topics related to poverty as well as cultural and generational communications.

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

Standard I—Coverage and Authorization of Services

While denial record reviews demonstrated that RMHP met all required decision time frames, RMHP's UM policies included inaccurate information regarding required time frames for standard prior authorization decisions, as well as extended time frames. In addition, several denial record reviews demonstrated that RMHP's reason for the ABD incorporated explanation of clinical criteria difficult for members with limited reading ability to understand. RMHP was required to:

- Correct information in its UM policies to accurately address time frames for making standard and extended authorization decisions.
- Ensure that the NABD letter in its entirely is written in language easy for a CHP+ member to understand.

RMHP: Trended Performance for Compliance With Regulations

Table 3-36 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 3-36—Compliance With Regulations Trended Performance for RMHP

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)*	**97%**	**91%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**100%**	**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 Systems (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 2019–2020.*

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

Trending scores over the past two review cycles indicate that RMHP improved performance in three of the 10 standards, with the greatest increase (48 percentage points) in Standard V—Member Information and slight increases (less than 10 percentage points) in performance in Standard IV—Member Rights and Protections and Standard VI—Grievance and Appeal Systems. RMHP maintained 100 percent compliance in two standards, Standard II—Access and Availability and Standard VIII—Credentialing and Recredentialing, and demonstrated somewhat consistent performance above 90 percent in Standard VII—Provider Participation and Program Integrity. RMHP experienced substantial declines of at or near 20 percentage points in performance in Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement. RMHP also experienced a slight decline (6 percentage points) in Standard I—Coverage and Authorization of Services. 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. HSAG recommends that RMHP evaluate its systems and processes and develop efforts to achieve its 100 percent performance demonstrated in previous review cycles in Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement.

Validation of Performance Measures

Compliance With Information Systems Standards

According to the 2020 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 3-37 shows the performance measure results for RMHP for HEDIS 2018 through HEDIS 2020, along with the percentile rankings for each HEDIS 2020 rate.

Table 3-37—Performance Measure Results for RMHP

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[2]				
Combination 2	64.80%	57.08%	**21.00%^^**	<10th
Combination 3	62.40%	57.08%	**20.50%^^**	<10th
Combination 4	60.40%	54.42%	**20.50%^^**	<10th
Combination 5	54.40%	54.87%	**16.00%^^**	<10th
Combination 6	41.20%	41.15%	**12.00%^^**	<10th
Combination 7	53.20%	52.21%	**16.00%^^**	<10th
Combination 8	41.20%	39.38%	**12.00%^^**	<10th
Combination 9	36.40%	39.82%	**11.00%^^**	<10th
Combination 10	36.40%	38.05%	**11.00%^^**	<10th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	60.87%	57.67%	62.86%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	13.71%	18.33%	20.32%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	5.00%	0.00%	3.85%	10th–24th
Six or More Visits	29.00%	15.79%	11.54%	<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	68.75%	67.68%	72.86%^	25th–49th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	47.07%	49.19%	51.31%	25th–49th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[2]	4.38%	4.83%	8.53%^	<10th
Counseling for Nutrition—Total	21.52%	23.00%	28.21%^	<10th
Counseling for Physical Activity—Total	3.51%	5.50%	7.89%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	93.48%	94.68%	95.62%	50th–74th
Ages 25 Months to 6 Years	83.49%	82.81%	87.76%^	25th–49th
Ages 7 to 11 Years	86.90%	88.00%	85.97%	10th–24th
Ages 12 to 19 Years	86.82%	87.04%	86.49%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	31.93%	33.57%	30.67%	<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				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	47.06%	53.33%	55.88%	75th–89th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total[3]	—	—	NA	—
Cholesterol Testing—Total[3]	—	—	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[3]				
Ages 3 to 17 Years	—	—	77.29%	—
Appropriate Treatment for Upper Respiratory Infection[3]				
Ages 3 Months to 17 Years	—	—	94.78%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[3]				
Ages 3 Months to 17 Years	—	—	69.66%	—
Medication Management for People With Asthma[2]				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
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[2]				
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)				
*Emergency Department Visits**	18.26	18.38	18.93	≥90th
Outpatient Visits	218.41	211.60	222.08	<10th
Inpatient Utilization—General Hospital/Acute Care[2]				
Discharges per 1,000 Member Months (Total Inpatient)	0.89	0.75	0.68	<10th
Average Length of Stay (Total Inpatient)	4.11	4.37	3.67	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.59	0.49	0.50	<10th
Average Length of Stay (Medicine)	3.29	3.27	3.02	<10th
Discharges per 1,000 Member Months (Surgery)	0.28	0.21	0.17	<10th
Average Length of Stay (Surgery)	5.91	7.46†	5.76†	<10th
Discharges per 1,000 Member Months (Maternity)	0.03	0.10	0.03	<10th
Average Length of Stay (Maternity)	2.50†	2.33†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.40	0.39	0.41	≥90th
Average Days Supplied per Antibiotic Script	10.18	10.20	20.51	<10th
Average Scripts PMPY for Antibiotics of Concern	0.14	0.14	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	35.07%	35.98%	33.22%	≥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 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure for 2019, NCQA recommends trending between 2019 and prior years be considered with caution.

[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 lower 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 statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

RMHP: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for RMHP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS 2019):

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

For HEDIS 2020, RMHP demonstrated strong performance ensuring children prescribed ADHD medication receive proper follow-up care. Additionally, the MCO continued to demonstrate strength ensuring that young women are not screened unnecessarily for cervical cancer.

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

The following HEDIS 2020 measure rates were determined to be low performers for RMHP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS 2019):

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *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 7 to 11 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 rates for the well-child/well-care visit measures and all indicator rates except one for the *Children and Adolescents' Access to Primary Care Practitioners* measure (*Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*) below the 50th percentile. Further, rates for *Childhood Immunization Status*, *Immunizations for Adolescents*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, and *Chlamydia Screening in Women* were below the 10th percentile for HEDIS 2020. Further, all measure rates for *Childhood Immunization Status* demonstrated a significant decline in performance from the previous year. However, RMHP did show significant improvement in performance for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total;* and *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* measures.

The MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., administrative data source challenges, are there issues related to barriers to accessing care) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.[3-2]

Validation of Performance Improvement Projects

Table 3-38 and Table 3-39 display the FY 2019–2020 validation findings for RMHP's *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP. During FY 2019–2020, RMHP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by RMHP are summarized in Table 3-38.

Table 3-38—Intervention Determination Summary for the *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP

Failure Modes	Potential Interventions
Member attends an appointment, but the care team does not identify the needed WCV services	Ongoing compliance program including staff education and follow-up to ensure that pre-visit planning (PVP) is consistently performed and communicated to the care team
Dental or behavioral health team does not identify member due for WCV services	• Dental and behavioral health PVP development with a whole-person approach and connection to all service lines • Inclusion in ongoing compliance program (described above)
No registry for tracking WCV services available	• Registry development • Use of registry to track targeted text message WCV reminders, incentives, and education for members

RMHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-39 summarizes the intervention RMHP selected for testing.

Table 3-39—Planned Intervention for the *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP

Intervention Description	Key Driver	Failure Mode
Registry-based outreach campaign to identify members due for well visits, send and track text message WCV reminders, and track scheduled and completed well visits	Ensure member knowledge of recommended annual well visit and the importance of preventative healthcare	No registry currently available to identify members due for a WCV

[3-2] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Sept 14, 2020.

RMHP: Strengths

RMHP continued work on a PIP focused on increasing the rate of well-child visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing its intervention through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, RMHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

Findings

Table 3-40 shows the results achieved by RMHP for FY 2017–2018 through FY 2019–2020.

Table 3-40—Top-Box Scores for RMHP

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	88.4%	90.1%	85.2%
Getting Care Quickly	91.8%	93.3%	94.9%
How Well Doctors Communicate	97.9%	97.1%	97.2%
Customer Service	83.9%	87.9%	84.3%+
Rating of Health Plan	63.2%	68.3%	69.3%
Rating of All Health Care	67.2%	67.7%	66.0%
Rating of Personal Doctor	72.8%	71.2%	72.0%
Rating of Specialist Seen Most Often	80.5%+	82.9%+	64.8%+ ▼

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

▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

RMHP: Strengths

For RMHP's CHP+ population, HSAG found no statistically significant increases in FY 2019–2020 compared to the previous year.

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

RMHP scored statistically significant lower in FY 2019–2020 than in FY 2018–2019 on one measure, *Rating of Specialist Seen Most Often*. Performance for this measure may be related to a variety of factors, including whether members felt they were able to get an appointment for their child to see a specialist as soon as they needed. HSAG recommends that RMHP explore what may be driving a statistically significant decrease in the score for this measure and develop initiatives for improvement, where appropriate.

Validation of Network Adequacy

RMHP: Strengths

During FY 2019–2020, RMHP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used RMHP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports. Table 3-41 summarizes HSAG's geoaccess analysis results by county classification for RMHP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met across all counties in which RMHP's members resided, and the percentage of standards met across all counties in which RMHP's members resided. While no CHP+ plan met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the CHP+ plans are working to address.

Table 3-41—RMHP's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	19	18	94.7%	19	17	89.5%	19	18	94.7%
Primary Care Time/Distance	7	6	91.2%	17	6	64.0%	8	6	65.2%
Physical Health Time/Distance	7	13	84.6%	17	13	19.5%	8	13	28.8%
Behavioral Health Time/Distance	7	3	100%	17	3	86.3%	8	3	95.8%
Facilities Time/Distance	7	4	60.7%	17	4	25.0%	8	4	46.9%

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

RMHP reported no practitioners for the Pediatric Ophthalmology network category. Further, RMHP's network data included no practitioners, practice sites, or entities for the Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals network categories. Consequently, RMHP failed to meet those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for the members residing in the contracted counties.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for RMHP's data values for provider type, specialty, and credentials. As such, HSAG recommends that RMHP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

DentaQuest

Assessment of Compliance With CHIP Managed Care Regulations

DentaQuest Overall Evaluation

Table 3-42 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 2019–2020.

Table 3-42—Summary of DentaQuest Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	17	16	11	5	0	1	69%
Standard II—Access and Availability	13	13	9	1	3	0	69%
Standard VI—Grievance and Appeal Systems**	30	30	4	14	12	0	13%
Totals	**60**	**59**	**24**	**20**	**15**	**1**	**41%***

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

***In FY 2019–2020, the Department requested review of an additional customized standard for DentaQuest.*

Table 3-43 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 2019–2020.

Table 3-43—Summary of DentaQuest Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	60	39	21	30	65%
Grievances**	42	35	24	11	7	69%
Appeals**	60	39	6	33	21	15%
Totals	**192**	**134**	**69**	**65**	**58**	**51%***

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

***In FY 2019–2020, the Department requested review of an additional customized standard for DentaQuest.*

DentaQuest: Strengths

DentaQuest's UM policies and procedures included guidelines and clinical criteria for dental benefit determinations based on State Medicaid guidelines, best practices, industry guidelines, American Medical Association guidelines, and various specialty association standards. DentaQuest's Peer Review Committee further developed clinical practice guideline algorithms to promote consistency and equity in clinical decisions. DentaQuest's UM processes included making clinical denials by persons with appropriate expertise, consulting with the requesting provider when appropriate, time frames for making standard and urgent prior authorization decisions, and providing a written NABD to the member.

DentaQuest offered a range of dental services for its members and had processes to monitor its network to evaluate the availability of providers, service locations, and service types. The provider directory had fields for language spoken, accommodations for mobility limitations, and whether the office had the capacity to treat members with neurobehavior diagnoses. DentaQuest had policies for providing a second opinion for members and provided urgent and emergent care outside the network. DentaQuest provided an annual cultural competency and diversity training to its providers and also used a telephonic language service to assist members in a variety of languages.

During the on-site review, HSAG identified evidence of DentaQuest's intent to have a grievance and appeal system in place, including policies, procedures, templates, and staffing resources to process grievances and appeals. HSAG observed that DentaQuest's system used to document grievances and appeals had fields to capture the required information.

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

Standard I—Coverage and Authorization of Services

During the on-site review, it was evident that organizational practices were not in place to effectively implement UM policies and procedures. HSAG found that many denials, grievances, and appeals were related to an insufficient network of providers, yet communication was limited between the grievance and appeal staff members and the provider network staff members related to insufficiency of the network. DentaQuest was required to develop a mechanism for interdepartmental communication so member grievances and appeals can be addressed in a way that meets the members' needs.

Although denial record reviews demonstrated that all denial decisions were made within the required time frames, DentaQuest's Authorization Review policy stated that standard decisions are made within 14 calendar days rather than the 10-day Colorado-specific time frame. DentaQuest was required to revise its UM policies to depict Colorado-specified time frames for making authorization determinations.

HSAG found in denial record reviews that DentaQuest's NABD demonstrated the following deficiencies: (1) the denial reason was unrelated to actual reason for the denial—e.g., lack of medical necessity instead of not a covered service; (2) listed the general Code of Colorado Regulations (CCR)

citation as the criteria used in making the denial decision, without explanation of the citation or criteria in easy-to-understand language; and (3) included numerous inaccurate time frames in describing the appeal and SFH process. DentaQuest was required to:

- Ensure that the reasons for denying services in the NABD are stated accurately to members and providers.
- Either remove the CCR citation from the NABD or provide additional language that is easy for the member to understand.
- Ensure that the appeal and SFH information and timelines in the NABD are accurate.

Standard II—Access and Availability

DentaQuest described internal credentialing issues that were preventing the credentialing of a sufficient quantity of providers to meet the needs of the members, resulting in members not getting needed services despite indication that they were experiencing dental pain. Further, staff members stated that they were not apprised of grievances or appeals that had been filed, which indicated a lack of cohesion between departments to ensure Colorado CHP+ members were receiving covered services. In addition, although there were policies that addressed out-of-network service provisions, DentaQuest provided no evidence of direction given to the UM staff members to allow out-of-network providers to furnish services until such time that the DentaQuest provider network is sufficient. Record review on-site revealed several cases where members were unable to receive services due to a lack of network providers and no out-of-network providers were approved. DentaQuest was required to:

- Ensure that providers are available in sufficient number, type, and specialty to furnish contracted services.
- Develop a mechanism to allow out-of-network providers to furnish services under the CHP+ contract with the Department for as long as it is unable to provide the services.

DentaQuest provided no evidence of having a mechanism—e.g., single-case agreement—to make arrangements with out-of-network providers for claims submissions and payment or to ensure that members are not charged more than if the services are provided by the network. DentaQuest was required to develop a mechanism to coordinate with the out-of-network providers for payment and to ensure that the cost to the member is no greater than it would be if the services were furnished within the network.

Although policies were provided, DentaQuest had not yet begun monitoring its Colorado CHP+ market to ensure providers were compliant with timely access standards. DentaQuest was required to establish mechanisms to ensure network providers' compliance with access (e.g., appointment) standards, monitor network providers regularly to determine compliance, and take corrective action if there is failure to comply.

Standard VI—Grievance and Appeal Systems

Although DentaQuest's grievance and appeal systems policies and procedures addressed some of the requirements at 42 CFR §438.400–424, many required provisions were missing, and the policies contained inaccuracies and contradictions. Staff members were unable to clearly articulate an understanding of the definitions of grievance, appeal, and provider reconsideration, and DentaQuest demonstrated organizational confusion regarding Colorado's required time frames for receiving and resolving grievances and appeals. DentaQuest's provider manual included no information about the appeal process and the member handbook included incomplete and inaccurate information about the processing of grievances and appeals. On-site record reviews revealed that incorrect reasons for denying service and upholding the original decision upon appeal were provided to members. Several grievance records contained resolution letters that were unresponsive to the members' needs. Several appeal records did not appear to take into consideration appeal information submitted by the member. All appeals were processed administratively, including those cases in which the original decision was based on medical necessity. DentaQuest was required to:

- Develop and implement effective training for complaints and grievance department staff members to ensure that staff members understand the federal grievance and appeal managed care regulations and Colorado's state-specific grievance and appeal time frames.
- Revise its policies, procedures, member and provider informational materials, and organizational processes to:
  - Ensure that any expression of dissatisfaction is treated and logged as a grievance.
  - Define that providers and authorized representatives may file an appeal or grievance and may request a SFH on behalf of the member with the member's written consent.
  - Ensure that members are afforded the right to provide consent for authorized representatives to file an appeal on their behalf.
  - Ensure consistently providing members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
  - Ensure that members understand that grievances are not required to be in writing to expect a response.
  - Ensure communication to members regarding the requirement to follow oral appeals with a written signed appeal is clear.
  - Ensure that members are provided accurate information in appeal resolution letters.
  - Include provisions that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date).
  - Include provisions that parties to the appeal and the SFH include the representative of a deceased member's estate.
  - Ensure that if the PAHP requires additional information and time to effectively process a grievance or appeal, an extension notice that includes the required content is provided to the member.
  - Accurately describe all required provisions of expedited review of appeals.
  - Accurately describe the internal appeals process.

  - Accurately describe the content of a grievance resolution letter.
  - Clearly differentiate between the provider reconsideration process, Medicaid member appeal processes, and CHP+ member appeals processes.
- Develop and implement effective processes to:
  - Ensure that members are afforded the right to provide additional evidence or testimony and to receive documents and records upon request at no charge.
  - Ensure that all comments, documents, records, and other information submitted by the member or the member's representative are considered when deciding the appeal without regard to whether such information was submitted or considered in the initial ABD.
  - Ensure compliance with the time frames for sending written grievance acknowledgement and resolution.
  - Ensure that appeal acknowledgement letters are sent within the two-working day required time frame.
  - Track the content of member appeal and grievance resolution letters for accuracy.
  - Ensure that written notice of the resolution of an expedited appeal is sent within 72 hours and that reasonable efforts to provide oral notice of the resolution also occurs.
  - Inform members that the request for a SFH must be in writing and is due within 120 days from the DentaQuest internal appeal resolution notice.

DentaQuest: Trended Performance for Compliance With Regulations

As this was the initial year of DentaQuest's CHP+ contract, no previous years' data are available for trending performance for compliance with managed care regulations.

Validation of Performance Measures

DentaQuest was not required to submit performance measures because its contract with the State started July 1, 2019; there, it did not have a full year of data for the CO CHP+ program.

Validation of Performance Improvement Projects

During FY 2019–2020, DentaQuest initiated the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP and completed Module 1, Module 2, and Module 3. Table 3-44 presents the FY 2019–2020 validation findings for Module 1 and Module 2.

Table 3-44—Validation Findings for the *Percentage of All Children Enrolled Under the Age of 21 Who Received At Least One Dental Service Within 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, 2021, increase the percentage of CHP+ members in the 3–5-year-old age group who reside in the Greeley area who utilized any dental service from 45.47% to 46.97%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 3–5 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.

For Module 3, DentaQuest identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by DentaQuest are summarized in Table 3-45.

Table 3-45—Intervention Determination Summary for the *Percentage of All Children Enrolled Under the Age of 21 Who Received At Least One Dental Service Within the Reporting Year* PIP

Failure Modes	Potential Interventions
• DentaQuest is unable to contact member to provide education about dental benefits • Member disregards mailed educational material or does not answer educational phone call	Educational outreach targeting specific non-compliant members through multiple modes of communication
Dental provider does not use provider portal to notify DentaQuest of missed appointment by member	Provider outreach and education on the importance of notifying DentaQuest via provider portal of missed member appointments
• Member does not receive geo-coded dental benefits letter • Member does not open geo-coded dental benefits letter	• Utilize enticing, visually appealing printed material to ensure members will want to read information on dental benefits • Outreach to community partners to explore co-branding options for printed dental benefits material
Local community partners provide inaccurate dental benefits information to members of the community	• Seek feedback from community members and community partners to improve dental outreach materials

Failure Modes	Potential Interventions
	• Improve accuracy and clarity of all materials, job aides, and presentations before training new community partners • Outreach and marketing collaboration to ensure all outreach material is easy to understand

DentaQuest also initiated Module 4, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-46 summarizes the intervention DentaQuest selected for testing.

Table 3-46—Planned Intervention for the *Percentage of All Children Enrolled Under the Age of 21 Who Received At Least One Dental Service Within the Reporting Year* PIP

Intervention Description	Key Driver	Failure Mode
Live outreach calls to parent/guardians of members with contact information verification and scheduling assistance	Awareness of dental benefits	DentaQuest is not able to contact member due to incorrect information

DentaQuest: Strengths

DentaQuest initiated a PIP focused on increasing utilization of dental services among members 3 to 5 years of age. The health plan passed Module 1, Module 2, and Module 3, achieving all validation criteria for these modules of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain dental services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a dental service. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to test its intervention through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, the next step in the rapid-cycle PIP process was for DentaQuest to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on dental utilization rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures

and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.

- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Surveys

No CAHPS survey was conducted for Colorado's dental PAHP, DentaQuest.

Validation of Network Adequacy

DentaQuest: Strengths

During FY 2019–2020, DentaQuest participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used DentaQuest's network data to conduct geoaccess analyses for dental services as a baseline to support the EQRO's future validation of the CHP+ plans' quarterly network adequacy reports.

Among the 14 urban counties, DentaQuest met the General Dentists network standard in 10 counties, met the Pediatric Dentists network standard in eight counties, and met the Dental Hygienists network standard in six counties.

Among the 27 rural counties, DentaQuest met the General Dentists network standard in 26 counties, met the Pediatric Dentists network standard in 12 counties, and met the Dental Hygienists network standard in 15 counties.

Among the 23 frontier counties, DentaQuest met the General Dentists network standard in 21 counties, met the Pediatric Dentists network standard in two counties, and met the Dental Hygienists network standard in nine counties.

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

DentaQuest's failure to meet the urban network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for a small percentage of the members residing in the applicable counties. Failure to meet the rural and frontier network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for DentaQuest's data values for provider type, specialty, and credentials. As such, HSAG recommends that DentaQuest continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

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	Denta-Quest[1]	Statewide Average
Standard I—Coverage and Authorization of Services (2019–2020)*	**78%**	**97%**	**63%**	**68%**	**91%**	**69%**	**78%**
Standard II—Access and Availability (2019–2020)*	**100%**	**88%**	**81%**	**100%**	**100%**	**69%**	**90%**
Standard III—Coordination and Continuity of Care (2018–2019)	100%	60%	78%	80%	80%	NA	80%
Standard IV—Member Rights and Protections (2018–2019)	88%	100%	88%	88%	88%	NA	90%
Standard V—Member Information (2017–2018)	100%	83%	92%	100%	100%	NA	95%
Standard VI—Grievance and Appeal Systems (2017–2018)	95%	91%	82%	68%	82%	**13%**[2]	84%
Standard VII—Provider Participation and Program Integrity (2017–2018)	100%	79%	93%	87%	93%	NA	90%
Standard VIII—Credentialing and Recredentialing (2018–2019)	100%	100%	86%	100%	100%	NA	97%
Standard IX—Subcontracts and Delegation (2017–2018)	NA	NA	NA	NA	NA	NA	NA
Standard X—Quality Assessment and Performance Improvement (2018–2019)	89%	89%	83%	89%	83%	NA	87%

**Bold text indicates standards reviewed by HSAG during FY 2019–2020.*

[1] FY 2019–2020 was the first year of review for DentaQuest.

[2] In FY 2019–2020, the Department requested review of an additional customized standard for DentaQuest. Results were not considered in the statewide average.

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

Record Review	COA	DHMP	FHP	Kaiser	RMHP	Denta-Quest	Statewide Average
Appeals (2017–2018)	93%	83%	100%	NA	83%	**15%[1]**	90%
Credentialing (2018–2019)	100%	100%	97%	100%	100%	NA	99%
Denials (2019–2020)*	**66%**	**83%**	**75%**	**66%**	**97%**	**65%**	**75%**
Grievances (2017–2018)	100%	NA	100%	75%	85%	**69%[1]**	89%
Recredentialing (2018–2019)	100%	100%	100%	100%	100%	NA	100%

**Bold text indicates standards reviewed by HSAG during FY 2019–2020.*

[1] In FY 2019–2020, the Department requested review of an additional customized standard for DentaQuest. Results were not considered in the statewide average.

NA: DHMP reported no CHP+ member grievances and Kaiser reported no CHP+ member appeals during the FY 2017–2018 review period. In addition, as FY 2019–2020 was the initial year of review for DentaQuest, no FY 2018–2019 credentialing or recredentialing results were available.

Statewide Conclusions and Strengths Related to Compliance With Regulations

For the two standards reviewed in FY 2019–2020, the CHP+ health plans demonstrated compliance in many areas.[4-1] All or most (three or more) CHP+ health plans demonstrated the following strengths:

- Maintained comprehensive policies, procedures, and processes for review and authorization of covered services.
- Maintained a panel of diverse medical reviewers, enabling clinically appropriate authorization decisions.
- Outreached to providers to obtain additional information, when necessary, and/or offered peer-to-peer consultation with providers prior to making authorization determinations.
- Demonstrated timeliness in making review decisions and sending NABDs within required time frames.
- Provided authorization decisions regarding covered outpatient drugs within 24 hours of request.
- Accurately defined "emergency medical condition," "emergency services," and "post-stabilization" per regulatory definitions.
- Required no authorization for emergency services in- or out-of-network.
- Provided that out-of-network post-stabilization services were no more costly to members than in-network services.
- Maintained an adequate network of providers for delivery of covered services.
- Used a variety of tools and resources to assess the provider network adequacy.

[4-1] Note: Although considered in the statewide conclusions, DentaQuest is a CHP+ dental PAHP and FY 2019–2020 was the first contract year of DentaQuest CHP+ operations; therefore, HSAG cautions that DentaQuest compliance results may not be comparable to the CHP+ MCOs.

- Monitored providers for timely appointment standards.
- Provided for out-of-network second opinions or when access to needed services was not available in network.
- Maintained policies and procedures to address cultural competency of providers and staff members.
- Provided cultural competency training for health plan staff and providers.

Statewide Conclusions and Recommendations Related to Compliance With Regulations

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

- Ensure the NABD is written in language easy for the member to understand.
- Correct inaccuracies in the content of the NABD to ensure that the NABD includes all required content.
- Ensure that UM policies and procedures include accurate time frames for making all authorization decisions and notifying the member of ABDs.
- Develop and implement processes for applying post-stabilization regulatory criteria in determining financial responsibility for post-stabilization services.
- Ensure that providers are monitored for compliance with all CHP+ appointment standards.

Validation of Performance Measures

In Table 4-3, MCO-specific and statewide weighted averages are presented for the CHP+ MCOs for HEDIS 2020. 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 for HEDIS 2020

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Pediatric Care						
Childhood Immunization Status						
Combination 2	72.06%	82.26%	0.00%	75.94%	21.00%	63.39%
Combination 3	70.04%	82.26%	0.00%	74.33%	20.50%	61.81%
Combination 4	68.02%	82.26%	0.00%	74.33%	20.50%	60.55%
Combination 5	61.31%	79.03%	0.00%	69.52%	16.00%	54.80%
Combination 6	53.22%	59.68%	0.00%	59.89%	12.00%	46.77%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Combination 7	59.92%	79.03%	0.00%	69.52%	16.00%	53.94%
Combination 8	51.83%	59.68%	0.00%	59.89%	12.00%	45.91%
Combination 9	47.53%	58.06%	0.00%	56.15%	11.00%	42.44%
Combination 10	46.78%	58.06%	0.00%	56.15%	11.00%	41.97%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	76.14%	86.71%	41.94%	82.33%	62.86%	74.81%
Combination 2 (Meningococcal, Tdap, HPV)	40.19%	53.80%	8.06%	53.67%	20.32%	39.20%
Well-Child Visits in the First 15 Months of Life						
*Zero Visits**	6.09%	2.22%	NA	1.69%	3.85%	4.66%
Six or More Visits	59.13%	66.67%	NA	76.27%	11.54%	56.22%
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	71.17%	71.33%	27.27%	65.50%	72.86%	69.68%
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	52.24%	52.41%	8.17%	46.58%	51.31%	50.21%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	11.78%	23.81%	13.69%	98.04%	8.53%	22.62%
Counseling for Nutrition—Total	6.66%	8.31%	5.38%	95.14%	28.21%	20.77%
Counseling for Physical Activity—Total	4.36%	7.41%	1.96%	95.14%	7.89%	16.17%
Access to Care						
Prenatal and Postpartum Care^						
Timeliness of Prenatal Care	—	—	—	—	—	61.38%
Postpartum Care	—	—	—	—	—	61.61%
Children and Adolescents' Access to Primary Care Practitioners						
Ages 12 to 24 Months	92.29%	90.00%	NA	91.30%	95.62%	92.44%
Ages 25 Months to 6 Years	86.12%	81.24%	67.27%	83.89%	87.76%	85.37%
Ages 7 to 11 Years	88.03%	84.85%	81.94%	89.45%	85.97%	87.58%
Ages 12 to 19 Years	87.93%	82.08%	83.17%	87.70%	86.49%	87.10%
Preventive Screening						
Chlamydia Screening in Women						
Ages 16 to 20 Years	34.07%	47.89%	NA	52.69%	30.67%	37.26%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Non-Recommended Cervical Cancer Screening in Adolescent Females*						
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	0.25%	0.00%	0.04%
Mental/Behavioral Health						
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	0.00%	NA	NA	NA	55.88%	14.98%
Continuation and Maintenance Phase	NA	NA	NA	NA	NA	32.69%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
Blood Glucose Testing—Total	60.58%	NA	NA	NA	NA	59.87%
Cholesterol Testing—Total	33.65%	NA	NA	NA	NA	39.47%
Blood Glucose and Cholesterol Testing—Total	30.77%	NA	NA	NA	NA	36.84%
Respiratory Conditions						
Appropriate Testing for Pharyngitis						
Ages 3 to 17 Years	85.48%	90.58%	65.81%	92.39%	77.29%	84.20%
Appropriate Treatment for Upper Respiratory Infection						
Ages 3 Months to 17 Years	92.27%	97.88%	91.67%	97.51%	94.78%	93.30%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis						
Ages 3 Months to 17 Years	72.11%	NA	NA	93.33%	69.66%	72.63%
Medication Management for People With Asthma						
Medication Compliance 50%—Ages 5 to 11 Years	62.50%	NA	NA	NA	NA	65.12%
Medication Compliance 50%—Ages 12 to 18 Years	60.22%	NA	NA	NA	NA	63.16%
Medication Compliance 75%—Ages 5 to 11 Years	40.00%	NA	NA	NA	NA	38.95%
Medication Compliance 75%—Ages 12 to 18 Years	35.48%	NA	NA	NA	NA	41.35%
Asthma Medication Ratio						
Ages 5 to 11 Years	87.60%	NA	NA	NA	NA	88.44%
Ages 12 to 18 Years	72.92%	NA	NA	NA	NA	70.21%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Use of Services†						
Ambulatory Care (Per 1,000 Member Months)						
*Emergency Department Visits**	27.08	22.57	20.17	21.93	18.93	24.91
Outpatient Visits	227.68	158.85	190.96	158.31	222.08	213.53
Inpatient Utilization—General Hospital/Acute Care						
Discharges per 1,000 Member Months (Total Inpatient)	1.02	1.05	0.32	0.69	0.68	0.92
Average Length of Stay (Total Inpatient)	3.40	2.59	1.71†	4.86	3.67	3.48
Discharges per 1,000 Member Months (Medicine)	0.76	0.79	0.37	0.46	0.50	0.68
Average Length of Stay (Medicine)	2.82	2.30	1.60†	3.35	3.02	2.83
Discharges per 1,000 Member Months (Surgery)	0.23	0.17	0.09	0.22	0.17	0.21
Average Length of Stay (Surgery)	5.36	3.90†	2.00†	8.17†	5.76†	5.63
Discharges per 1,000 Member Months (Maternity)	0.08	0.16	0.00	0.02	0.03	0.07
Average Length of Stay (Maternity)	3.43†	2.60†	NA	3.00†	2.00†	3.19
Antibiotic Utilization*						
Average Scripts PMPY for Antibiotics	0.35	0.18	0.42	0.29	0.41	0.34
Average Days Supplied per Antibiotic Script	10.70	10.88	102.83	11.52	20.51	15.10
Average Scripts PMPY for Antibiotics of Concern	0.12	0.04	0.15	0.08	0.14	0.11
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.07%	23.74%	35.97%	27.59%	33.22%	32.33%

** For this indicator, a lower rate indicates better performance.*
— Indicates that the MCOs were not required to report this measure for HEDIS 2020.
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, 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.
^The SMCN is the only CHP+ health plan required to report the Prenatal and Postpartum Care measure.

Statewide Strengths

The following HEDIS 2020 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019; or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2019) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combination 9*

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years* and *Ages 12 to 18 Years*, *Medication Compliance 75%—Ages 5 to 11 Years* and *Ages 12 to 18 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years*

The State continued to demonstrate strength by not screening young women unnecessarily for cervical cancer and by ensuring providers appropriately manage medication for members with asthma.

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

The following HEDIS 2020 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS 2019) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2–5* and *7*
- *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 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*

Statewide performance for HEDIS 2020 demonstrated opportunities to improve the access to preventive care and services for members, including well-child/well-care visits, immunizations, chlamydia screening, and follow-up care for members prescribed ADHD medications.

Validation of Performance Improvement Projects

Table 4-4 shows the FY 2019–2020 statewide PIP results for the CHP+ health plans.

Table 4-4—FY 2019–2020 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 3 and Initiated Module 4*	NA*
DHMP	*Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
FHP	*Well-Child Visits in the 6th Through 14th Years of Life*	*Completed Module 3 and Initiated Module 4*	NA*
Kaiser	*Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
RMHP	*Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18*	*Completed Module 3 and Initiated Module 4*	NA*
DentaQuest	*Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year*	*Completed Modules 1 through 3 and Initiated Module 4*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2019–2020 validation cycle.*

During FY 2019–2020, the CHP+ health plans continued rapid-cycle PIPs that were initiated in FY 2018–2019, focusing on topics approved by the Department. For DentaQuest, this was the first year for the PIP and the CHP+ health plan initiated the PIP and completed Module 1 and Module 2 in FY 2019–2020, prior to progressing to Module 3. The PIPs addressed the following topic areas:

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

The PIPs were scheduled to continue into the next FY, to be evaluated on outcomes and receive a final validation status after completion of all five modules of the rapid-cycle PIP process and submission of final documentation for validation. Due to the COVID-19 pandemic, the Department decided to close-out the PIPs at the end of FY 2019–2020, prior to the completion of the final PIP modules. The CHP+ health plans were instructed to submit a PIP close-out report and will initiate a new round of PIPs in FY 2020–2021.

During the FY 2019–2020 validation cycle, the CHP+ health plans received training and technical assistance on methods for identifying and testing interventions as part of the rapid-cycle PIP process. The CHP+ health plans submitted documentation on Module 3, and the intervention testing plan for Module 4, for a total of six PIPs. HSAG provided feedback to the CHP+ health plans on the initial Module 3 submissions and the CHP+ health plans revised the module documentation and resubmitted Module 3 until all criteria were achieved. The CHP+ health plans passed Module 3, achieving all validation criteria for all six PIPs. After passing Module 3, the CHP+ health plans initiated Module 4 by submitting a plan for testing one or more interventions. HSAG provided pre-validation feedback to the CHP+ health plans on the intervention testing plans. After receiving HSAG's pre-validation feedback, the CHP+ health plans began testing interventions through PDSA cycles as part of Module 4. Module 4 activities were paused after March 2020, when the Department allowed the CHP+ health plans to close out the PIPs early in response to competing priorities and resource limitations related to the COVID-19 pandemic.

Statewide Conclusions and Recommendations for PIPs

The FY 2019–2020 validation findings for all six PIPs suggested that all CHP+ health plans used robust quality improvement methods to identify appropriate interventions to address the Department-approved PIP topics and developed plans to test the effectiveness of these interventions through PDSA cycles. The CHP+ health plans used process mapping and FMEA to examine processes related to the PIP topics, identify and prioritize failures or gaps in these processes, and determine appropriate interventions to address high-priority process failures. HSAG recommended the following as the health plans initiated PDSA cycles to test interventions for Module 4 of the PIPs:

- To ensure a methodologically sound intervention testing methodology, health plans should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The key driver diagram for the PIP should be updated regularly to incorporate all interventions tested and any knowledge gained, and lessons learned as health plans progresses through PDSA cycles.
- When reporting the final PIP conclusions, health plans should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and any demonstrated improvement.

CAHPS Surveys

Statewide Results for CAHPS

The Colorado CHP+ Program results presented in Table 4-5 are derived from the combined results of the five CHP+ health plans. Table 4-5 shows the FY 2019–2020 health plan-level and Colorado CHP+ Program results for each CAHPS measure.[4-2]

Table 4-5—Statewide Comparison of Top-Box Scores

Measure	COA	DHMP	FHP	Kaiser	RMHP	Colorado CHP+ Program
Getting Needed Care	85.2%	78.7%	82.2%+	83.9%	85.1%	83.7%
Getting Care Quickly	91.2%	87.4%	93.5%+	85.5% ↓	94.7% ↑	90.9%
How Well Doctors Communicate	97.6%	97.5%	98.7%+	96.2%	97.0%	97.5%
Customer Service	79.7%+ ↓	85.9%+	97.4%+ ↑	89.9%+	84.0%+	82.3%
Rating of Health Plan	62.7%	63.4%	59.7%	62.6%	69.3%	63.3%
Rating of All Health Care	69.3%	65.5%	59.9%+	72.1%	66.2%	68.8%
Rating of Personal Doctor	78.1%	86.7% ↑	73.7%	77.6%	71.8% ↓	77.6%
Rating of Specialist Seen Most Often	76.1%+	73.6%+	75.9%+	65.2%+	65.3%+	71.6%

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

Colorado CHP+ Program scores are added for reference.

↑ *Indicates the plan's score is statistically significantly higher than the Colorado CHP+ Program.*
↓ *Indicates the plan's score is statistically significantly lower than the Colorado CHP+ Program.*

Statewide Conclusions and Recommendations for CAHPS

Each CHP+ health plan had statistically significant differences of member and family perceptions regarding the quality of care and services they received compared to the Colorado CHP+ Program. Three of the eight measures showed statistically significant results.

- FHP scored statistically significantly higher than the Colorado CHP+ Program for one measure, *Customer Service*.
- COA scored statistically significantly lower than the Colorado CHP+ Program for one measure, *Customer Service*.

[4-2] The CHP+ health plan results were case-mix adjusted to account for disparities in respondents' demographics for comparability among the health plans. Due to case-mix adjustment, the results of the five CHP+ health plans may be different than the results in Section 3 of this report.

- RMHP scored statistically significantly higher than the Colorado CHP+ Program for one measure, *Getting Care Quickly*. Conversely, RMHP scored statistically significantly lower than the Colorado CHP+ Program for one measure, *Rating of Personal Doctor*.
- Kaiser scored statistically significantly lower than the Colorado CHP+ Program for one measure, *Getting Care Quickly*.
- DHMP scored statistically significantly higher than the Colorado CHP+ Program for one measure, *Rating of Personal Doctor*.

The Department may want to consider statewide initiatives to improve scores for measures that were statistically significantly lower than the Colorado CHP+ Program or conduct studies to further evaluate the key drivers that may have impacted statistically significantly lower scores related to timeliness of care, customer service, and parents'/caretakers' experiences with their children's personal doctors.

Validation of Network Adequacy

Statewide Results

In addition to collaborating with the Department to develop and implement standardized quarterly network adequacy reporting templates, HSAG used network crosswalk files developed during FY 2018–2019 to calculate standard, health plan-specific geospatial analyses as a baseline for future validation of the CHP+ health plans' network adequacy. The geoaccess calculation results highlight the importance of using consistent network categories and geoaccess analysis methods across health plans to systematically assess the health plans' compliance with network standards.

Overall, no CHP+ plan met all network standards across all counties in each county designation. In general, failure to meet the contract standards was largely attributable to some instances in which the closest network locations were outside the required standard. However, the CHP+ plans were responsible for only a small number of members (i.e., fewer than 50 members) residing in counties in which the network access standards were not met. With the exception of DHMP CHP+ and RMHP CHP+, no CHP+ plans reported Pediatric Primary Care (Mid-Level) practitioners in their network data. Additionally, four CHP+ plans did not have a sufficient number of Pediatric Ophthalmology practitioners to meet the network standards for their members in selected counties. Each CHP+ plan, however, reported an adequate overall number of primary care practitioners (i.e., Adult and Pediatric Primary Care Provider, Gynecology, Family Practitioner) across each county type, though the CHP+ plan may not have had adequate network locations to meet each network standard in each county.

Likewise, overall, DentaQuest did not meet all network standards across all counties in each county designation. DentaQuest reported low rates of specialty dental practitioners in rural and frontier counties and extremely low rates of prosthodontists in urban counties. However, DentaQuest reported an adequate number of dental practitioners for the primary dental care network categories (e.g., General Dentists, Pediatric Dentists, and Dental Hygienists).

While no health plan met all network contract standards, the contract requirement for the health plan to meet each network standard for 100 percent of its members presents a potential barrier to health plans meeting the contract standards for areas in which practitioners are physically unavailable. For example, a health plan may have 99 percent of members in an urban county residing within the required time or distance of at least two primary care providers (PCPs); however, the health plan would fail to meet the network standard for the county because less than 100 percent of members resided within the required travel time or driving distance. HSAG's use of consistent calculation methods allows the Department to use the FY 2019–2020 geoaccess analysis results to identify instances in which a health plan's failure to meet network contract standards may be attributed to one or more of the following scenarios:

- Data concerns (e.g., the health plan failed to include practitioners in its network calculations or data submissions to the Department)
- Network deficiencies (e.g., no practitioners are available and/or willing to contract with the health plan in a given county)
- A limited number of members residing outside the contract standard (e.g., rural or frontier areas with a limited number of specialty providers)

Statewide Conclusions and Recommendations

The FY 2019–2020 NAV findings highlight the importance of consistent network category attribution as a foundation from which to assess whether the health plans' lack of compliance with selected network standards may stem from data-related concerns versus a lack of available network locations. In developing and implementing standardized network adequacy templates and supporting documentation for the health plans' quarterly reporting, the FY 2019–2020 NAV study established a foundation from which the Department can standardize its process for requiring and reviewing health plans' requests for exemptions to the network contract standards, ensuring comprehensive access to care for all CHP+ members.

Based on the first standardized calculations of the health plans' compliance with network adequacy geoaccess standards, HSAG offers the following recommendations to improve network adequacy data and oversight:

- The Department made significant progress during FY 2019–2020 in developing and implementing quarterly network adequacy reporting materials that are standardized within and across health plan types (e.g., CHP+ MCOs, SMCN, and PAHP). The Department should continue to refine and automate the quarterly network adequacy reporting process to reduce duplication of reporting and oversight efforts for the Department and the health plans, and to facilitate routine NAV by an external entity.
- HSAG's network data review identified varying levels of missingness by health plan for network category assignments, as well as spelling variations and/or use of special characters for the health plans' data values for provider type, specialty, and credentials.

  - The health plans should continue to assess available data values in their network data systems and standardize available data value options and network category attribution.
  - The Department should incorporate data verification processes into the quarterly network adequacy report reviews.
- The Department should review the network categories for which the health plans failed to meet the time/distance standards, and request that the health plans confirm whether failure to meet the time/distance network access standard(s) resulted from concerns with the health plan's network category data attributions, a lack of network locations for the specific geographic area, or the health plan's inability to contract with available network locations in the geographic area.
- The Department should consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data supplied to members and used for geoaccess analyses.
- As the time/distance results represent the potential geographic distribution of contracted network locations and may not directly reflect network availability at any point in time, the Department should consider using appointment availability surveys to evaluate health plans' compliance with contract standards for access to care. HSAG also recommends incorporating encounter data to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate network availability.
- In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department should review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care.

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

Colorado Access

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2018–2019, HSAG reviewed four standards: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

For Standard VI—Member Rights and Protections, COA had one required action:

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

For Standard X—Quality Assessment and Performance Improvement, COA had two required actions:

- Implement mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs (SHCN).
- Implement an annual process for evaluating the impact and effectiveness of the CHP+ Quality Assessment and Performance Improvement (QAPI) program.

COA submitted its initial corrective action plan (CAP) proposal on April 22, 2019, and, following Department approval, completed implementation of all planned interventions on August 16, 2019, bringing COA into full compliance with these standards.

Validation of Performance Measures

To improve its HEDIS rates from last year, COA decided to focus on the following interventions:

- For the *Asthma Medication Ratio*, *Medication Management for People With Asthma*, *Adolescent Well-Care Visits*, *Childhood Immunization Status*, and *Immunizations for Adolescents* measures, COA administered Health Risk Assessments (HRAs) to new CHP+ members. The HRA is used to assess the member's health risk and quality of their health. Once received, the HRA is loaded into the care management tool, and any members whose answers indicate a need for follow-up are outreached by a care manager. These callbacks lead to care coordination in the form of identifying primary care, behavioral health, or dental needs and scheduling a first appointment with a provider.
- For the *Adolescent Well-Care Visits, Childhood Immunization Status,* and *Immunizations for Adolescents* measures, COA continued its collaboration with Community Health Provider Alliance (CHPA) and identified member use of preventive services as an area of opportunity for collaboration and strategic performance improvement. COA provided CHPA clinics a $1.25 per member per

month (PMPM) incentive to support care coordination for its attributed members, paid monthly. COA and CHPA initiated a joint work plan to increase the number and percentage of COA CHP+ members who receive well-child checks, and subsequently immunizations, from their attributed CHPA clinic.

- For the *Asthma Medication Ratio* and *Medication Management for People With Asthma* measures, COA implemented an asthma program that used a telephonic outreach program designed to educate high-risk members and/or guardians about the diagnosis and management of asthma. Through an asthma-specific assessment, the care manager assisted in the identification of member health needs and/or social barriers. A care plan was then crafted to reflect member and/or caregiver preferences.
- For the *Adolescent Well-Care Visits* measure, COA continued the rapid-cycle PIP to target well-visit rates for members ages 10–14 years by collaborating with STRIDE Community Health Center (STRIDE) to perform a PDSA cycle to test interventions to increase well-visit rates. Important components of this work included targeted telephone outreach to members ages 10–14 years who had not received a well-visit in the previous 12 months, as well as a face-to-face training and ongoing support to STRIDE on best-practices for increasing well-visit rates. COA monitored well-visit rates for members ages 10–14 years attributed to STRIDE monthly to determine if interventions were effective, and intervention points were pivoted where necessary.
- COA partnered with Nativitus, the PBM, to provide additional programming to providers and members. The Navitus Asthma Program included notifications sent to the member's guardian and the prescribing physician with a member-specific asthma medication profile and a reminder to schedule a medication management appointment.
- COA used an asthma digital engagement campaign that delivered condition-specific information on self-management education to members who are categorized as being lower risk (e.g., history of managing their condition in primary care). This program is founded on COA's clinical utilization asthma registry and clinical guidance from the National Institutes of Health's Asthma Care Quick Reference Guide.[5-1] The digital engagement campaign aligns with the care management intervention and supports members in improving their disease state, implementing asthma action plans, and increasing member management of their own condition. Members were also provided the care management phone number for additional care and services.

[5-1] U.S. Department of Health and Human Services, National Institutes of Health. *Asthma Care Quick Reference: Diagnosing and Managing Asthma*. Bethesda, MD: National Heart, Lung, and Blood Institute, 2012. Available at: https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf.

Validation of Performance Improvement Projects

In FY 2018–2019, COA initiated the *Well-Child Visits for Members 10–14 Years of Age* PIP. HSAG recommended 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.

In FY 2019–2020, COA passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that COA addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. COA also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations, related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Surveys

To follow up on recommendations related to FY 2018–2019 CAHPS, COA reported engaging in the following quality improvement initiatives:

- COA implemented two programs within the customer service department that focus on continuous monitoring of customer service quality and identify areas of improvement. The Quality Monitoring Program, an ongoing program, scores and monitors customer service representatives (CSRs) to identify areas of improvement based on the program guidelines. Additionally, COA invests in a Net Promoter Score (NPS) system, a short survey, to monitor member satisfaction with the service they received from COA CSRs. Along with these programs, CSRs participate in a four-week training program that includes a comprehensive review of member benefits and department workflows, training on all applicable systems, and trainees take mock and live calls in the training environment before they are released to the floor.

- COA provided education and training to the highest volume of provider entities on the importance of well visits for members as it relates to preventing illness and supporting members and their families with their psychosocial and developmental concerns. In addition, COA will provide well-visit messaging to target PCPs on the importance of wellness activities to empower providers to provide quality preventative care to members.
- COA initiated a satisfaction survey for members who call customer service to monitor the members' experience with access, timeliness, and quality of care provided by COA-contracted providers. Results from the survey will be analyzed to identify key drivers for customer satisfaction and opportunities for improvement.
- COA will resume several planned interventions/strategies involving providers and members when the COVID-19 crisis decreases in severity.

Validation of Network Adequacy

During FY 2019–2020, COA participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. COA continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Denver Health Medical Plan, Inc.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2018–2019, HSAG reviewed four standards: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

For Standard III—Coordination and Continuity of Care, DHMP had four required actions:

- Provide continuity of care for newly enrolled members.
- Ensure each CHP+ member has an ongoing source of care and is informed of how to contact his or her provider.
- Conduct an initial screening of each new member's health needs.
- Ensure each member with SHCN receives a comprehensive assessment.

For Standard X—Quality Assessment and Performance Improvement, DHMP had two required actions:

- Implement mechanisms to detect both under- and overutilization of services within its QAPI program.
- Assess quality of care rendered to members with SHCN.

DHMP submitted its initial CAP proposal on March 15, 2019, and, following Department approval, completed implementation of all planned interventions on January 31, 2020, bringing DHMP into full compliance with these standards.

Validation of Performance Measures

To improve its HEDIS rates from last year, DHMP decided to focus on the following interventions:

- DHMP maintained and expanded active partnership and collaboration in quality improvement work group activities with ACS on several quality improvement interventions in chronic disease management, prevention, screening, and annual visits. Work groups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated behavioral health, transitions of care, immunizations, and the ambulatory care Quality Improvement Committee (QIC).
- DHMP continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS scores.
- DHMP continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores.

- DHMP increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- For the *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Childhood Immunization Status*; and *Immunizations for Adolescents* measures, DHMP sent out Healthy Hero Birthday Cards for members 19 and under. The birthday cards are intended to provide visit reminders as well as prepare and educate children and parents on what will happen at upcoming well-child visits. DHMP also conducted outreach calls for well-child and adolescent well-care visits. In addition, DHMP used SBHCs to provide a variety of services such as well-child visits, sports physicals, immunizations, chronic disease management, and primary care and behavioral health care services.
- For the *Medication Management for People With Asthma* and *Asthma Medication Ratio* measures, DHMP had its Asthma Work Group (AWG) and registered nurse line utilize a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. In addition, the DHMP pharmacy team has directed more focus on the need to refill asthma controller medications on a consistent basis and will begin utilizing a pharmacy vendor tracking system in FY 2020-2021 to streamline this process.
- In the Access to Care domain, DHMP introduced several strategies to reduce the wait list, including an improved new patient workflow for the appointment center, the hiring and placement of providers in key locations, collaboration between the appointment center and clinics to fill open appointment slots, and adjusted provider panel sizes.
- DHMP collaborated with ACS care coordination to increase assessment of members for gaps in care and problem solving to achieve a more comprehensive member approach to care and services.
- DHMP continued a pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization.
- DHMP incorporated data from ACS electronic medical records into supplemental files used for HEDIS reporting.
- DHMP maintained reporting of quality of care concerns (QOCCs) and facilitated process improvements as identified during the QOCC review process.
- DHMP developed clinical practice guidelines to cover the lifespan from infancy to geriatric.
- DHMP streamlined clinical and preventive guidelines review and is updating the process.
- DHMP increased physician involvement in the development of clinical practice guidelines.
- DHMP continued development, review, and revision of policies and procedures annually through electronic tracking through the organization's transition to an updated system, PolicyStat.
- DHMP maintained physician involvement within the Quality Management Committee (QMC) structure.

Validation of Performance Improvement Projects

In FY 2018–2019, DHMP initiated the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP. HSAG recommended 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.

In FY 2019–2020, DHMP passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that DHMP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. DHMP also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Surveys

To follow up on recommendations related to FY 2018–2019 CAHPS, DHMP reported engaging in the following quality improvement initiatives:

- DHMP improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores.
- DHMP increased member support outreach through ACS initiatives to follow up on gaps in care and preventive health screenings.
- DHMP focused on member outreach for facilitating care transitions.
- DHMP developed and implemented enhanced patient education materials specific to chronic diseases.

- DHMP uses the DHHA system to provide greater appointment availability by expanding capacity, provider communication, hours of operation, and specialty services.
- DHMP uses the Health Plan Customer Service Team to perform sample audits of calls for bimonthly discussion and provide real-time training for staff members regarding member service call quality improvement.
- DHMP worked with the member services department to develop a work plan that outlines the processes to effectively track the reasons members state for not getting the help or information they needed to assist in identifying process improvement and staff training opportunities.
- DHMP works collaboratively with ACS clinics, providers, committees, and DHHA to perform a quality review of cases regularly and improve the referral process.
- DHMP performs a health needs assessment (HNA) of all new members. The results of the HNA are communicated to the care coordination team, who directly follows up with the member to provide general information, resources, and support.
- DHMP built a risk stratification tool to monitor, analyze, and target members' specific health conditions, needs, and issues and directly provide education and resources.

Validation of Network Adequacy

During FY 2019–2020, DHMP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. DHMP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Friday Health Plans of Colorado

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2018–2019, HSAG reviewed four standards: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

For Standard III—Coordination and Continuity of Care, FHP had two required actions:

- Coordinate services with other managed care and fee-for-service (FFS) plans.
- Ensure members or family members consent to the medical treatment plan.

For Standard IV—Member Rights and Protections, FHP had one required action:

- Include in its written advance directives policies provisions for providing advance directive information to the member's family or surrogate if the member is incapacitated at the time of initial enrollment.

For Standard VIII—Credentialing and Recredentialing, FHP had four required actions:

- Two required actions related to ensuring the provider is not accepted into the network prior to all required information being received and reviewed.
- Ensure credentialing of organizational providers every 36 months.
- Include in written processes requirements related to on-site quality assessment of organizational providers.

For Standard X—Quality Assessment and Performance Improvement, FHP had three required actions:

- Systematic detection and review of over- and underutilization.
- Assess quality of care for members with SHCN.
- Implement a process to ensure UM and other decisions are consistent with clinical practice guidelines.

FHP submitted its initial CAP proposal on February 25, 2019, and, following Department approval, completed implementation of all planned interventions on January 8, 2020, bringing FHP into full compliance with these standards.

Validation of Performance Measures

To improve its HEDIS rates from last year, FHP decided to focus on the following interventions:

- FHP brought its internal teams and external partners together to work out the details for more robust data in order to get actionable items to close gaps through member outreach.
- FHP's provider operations team is taking a more a data-driven approach to provider outreach.
- FHP worked with its providers to get into alignment around the importance of delivering and reporting identified services. FHP also initiated more collaboration between the health plan and the providers in order to achieve greater impacts to member care.
- FHP's marketing department provided excerpts to members through member portals, social media, and outreach related to various topics, such as mental health, immunization, well care, etc.
- FHP made changes to the telephone queues in customer service, so that members receive more direct access to member-focused representatives while providers have a separate queue.
- FHP implemented care managers for case management.
- FHP provided updates to enhance member portals to provide more in-depth details to members related to benefits, providers, and access to care.

Validation of Performance Improvement Projects

In FY 2018–2019, FHP initiated the *Well-Child Visits in the 6th Through 14th Years of Life* PIP. HSAG recommended 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.

In FY 2019–2020, FHP passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that FHP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. FHP also initiated Module 4 and made a prediction

as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Surveys

To follow up on recommendations related to FY 2018–2019 CAHPS, FHP reported engaging in the following quality improvement initiatives:

- FHP brought its internal teams and external partners together to obtain more robust data used to determine actionable items to close gaps through member outreach.
- FHP is collaborating more with the providers to get into alignment around the importance of delivering and reporting identified services and achieve greater impacts related to member care.
- FHP's marketing department provides excerpts related to various topics, such as mental health, immunization, and well care to members through member portals and social media. FHP enhanced the member portals to provide more in-depth details to members related to benefits, providers, and access to care.
- FHP changed how providers and members are managed in the customer service telephone line queue. Members have more direct access to member-focused representatives and providers are directed to a separate queue.
- FHP implemented care managers for case management.

Validation of Network Adequacy

During FY 2019–2020, FHP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. FHP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Kaiser Permanente Colorado

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2018–2019, HSAG reviewed four standards: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

For Standard III—Coordination and Continuity of Care, Kaiser had two required actions:

- Enhance procedures for providing continuity of care to newly enrolled members.
- Define and implement a process to conduct an initial assessment of each new member's needs that incorporates screening for all required assessment criteria.

For Standard IV—Member Rights and Protections, Kaiser had one required action:

- Clarify the description of member rights in member and provider materials to state that members have the right to receive information from the health plan in plain language, in English or an alternative language, and that takes the member's communication impairments into consideration.

For Standard X—Quality Assessment and Performance Improvement, Kaiser had two required actions:

- Detect and analyze over- and underutilization of services within the QAPI program.
- Assess the quality and appropriateness of care rendered to members with SHCN.

Kaiser submitted its initial CAP proposal on March 20, 2019, and, following Department approval, completed implementation of all planned interventions on August 22, 2019, bringing Kaiser into full compliance with these standards.

Validation of Performance Measures

To improve its HEDIS rates from last year, Kaiser decided to focus on the following interventions:

- For the *Adolescent Well-Care Visits* measure, Kaiser continued to provide access to members outside the context of an office visit. These included chats with a physician, video visits, and walk-in immunization visits.
- For the *Childhood Immunization Status* measure, Kaiser continued the use of automated in reach and outreach prompts, supplemented by new outreach and reminder activities by a team of navigators.

Validation of Performance Improvement Projects

In FY 2018–2019, Kaiser initiated the *Improving CHP+ Adolescent Well-Visit Adherence* PIP. HSAG recommended 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.

In FY 2019–2020, Kaiser passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that Kaiser addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. Kaiser also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Surveys

To follow up on recommendations related to FY 2018–2019 CAHPS, Kaiser reported engaging in the following quality improvement initiatives:

- Kaiser kicked off the intervention strategy “Extended Daily Hours and Weekend Hours at all Medical Office Buildings.”
- Kaiser will continue to focus on the inclusion of telehealth within the “Additional Modes of Care” intervention strategy and move forward with a “Virtual First Phase 2.”
- Kaiser put together a team of specialists at the children’s hospital to understand most of the problem areas of pediatric specialty care, which helped diminish the confusion and frustration from communicating and transitioning orders from one organization to another.

- Kaiser met with the children's hospital's specialty board to improve relationships and provide education on the availability of Kaiser's tools. Physician-to-physician messaging allows physicians from each organization to communicate directly through a messenger service, which benefits referrals, tests, and overall partnership. Provider partner tools help support the patient while placing orders and reviewing results. The Affiliate Link and Care Everywhere portal allows non-Kaiser providers and staff members to act on behalf of Kaiser members within the Kaiser system. Kaiser will continue to work on improved relationships when the COVID-19 crisis decreases in severity.
- Kaiser's customer service work plan is monitored quarterly.
- Kaiser extended hours at all medical office buildings, including weekend hours.
- Kaiser added enhancements to virtual care including online chats with a doctor, pharmacist, or financial counselor.
- Kaiser initiated additional contracts with DispatchHealth where an urgent care provider will go to the member's home to avert unnecessary emergency room utilization.
- Kaiser implemented culture matters training, a two-day workshop for the organization to improve customer service, teamwork, and overall culture within the organization.
- Kaiser implemented the Member Perception of Access (MPA) survey and will evaluate the data to assess members' satisfaction, identify opportunities, and develop a plan for improvement with providers.

Validation of Network Adequacy

During FY 2019–2020, Kaiser participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. Kaiser continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Rocky Mountain Health Plans

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2018–2019, HSAG reviewed four standards: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

For Standard III—Coordination and Continuity of Care, RMHP had two required actions:

- Develop a mechanism to inform a member how to contact his or her PCP for ongoing coordination of healthcare services.
- Implement an expanded intake assessment that addresses all Department-required elements of the health screening.

For Standard IV—Member Rights and Protections, RMHP had one required action:

- Develop provisions for community education regarding advance directives.

For Standard X—Quality Assessment and Performance Improvement, RMHP had three required actions:

- Systematically detect and determine concerns regarding both underutilization and overutilization of services within its QAPI program.
- Assess the quality and appropriateness of care furnished to members with SHCN.
- Enhance internal procedures to ensure that decisions for UM, member education, coverage of services, and other areas to which clinical practice guidelines apply are consistent with adopted guidelines.

RMHP submitted its initial CAP proposal on May 6, 2019, and, following Department approval, completed implementation of all planned interventions on September 16, 2019, bringing RMHP into full compliance with these standards.

Validation of Performance Measures

To improve its HEDIS rates from last year, RMHP decided to focus on the following interventions:

- For the *Child Immunization Status* measure, RMHP sent out a New Baby Packet that is an educational brochure that is mailed after birth and includes recommended well-child visit schedules for immunizations. RMHP also sent out Child's First Birthday cards, which are educational brochures mailed at 12 months age and include education about why to immunize, how immunizations work, what happens if the child is not immunized, and a typical immunization

schedule from the Centers for Disease Control and Prevention (CDC). RMHP also sent additional brochures on birthdays and included immunization reminders.

- For the *Immunizations for Adolescents* measure, RMHP used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of a wellness visit including immunizations for meningococcal meningitis and influenza.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, RMHP used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of a wellness visit including body mass index (BMI) calculation and discussion of eating habits and physical activity. RMHP also sent out a Fall Provider Newsletter, which included an article that discussed education specific to adolescent and well-child visit documentation.
- For the *Medication Management for People With Asthma* and *Asthma Medication Ratio* measures, RMHP deployed a chronic disease management program for asthma. The purpose of the disease management program was to connect members to a PCP if they did not have a medical home, identify gaps in care, address social determinants of health needs, and provide care coordination.

Validation of Performance Improvement Projects

In FY 2018–2019, RMHP initiated the *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP. HSAG recommended 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.

In FY 2019–2020, RMHP passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that RMHP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. RMHP also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation

measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Surveys

To follow up on recommendations related to FY 2018–2019 CAHPS, RMHP reported engaging in the following quality improvement initiatives:

- RMHP promoted "Destination RMHP," a website containing a series of podcasts hosted by RMHP's Practice Transformation team. These podcasts include interviews with healthcare professionals with tips about improving communication and building patient relationships.
- RMHP continued to contact new members through the welcome call process and periodically updated the script based on feedback received through audits and from members.
- RMHP analyzes Service Form reports to identify and address any increase in volumes.
- RMHP sent a Spanish version of the "Getting Started Guide" to new members who indicated Spanish is their primary language. RMHP added a language field to packets to assist with gathering this information.
- RMHP follows up with members who provide negative responses during NPS calls. The follow-up includes a phone outreach by an Advocate4Me staff member. In addition, a designated customer advocate reviews complaints and contacts members to address concerns.
- RMHP provides an educational video series for providers produced by the Practice Transformation Team in partnership with the RMHP Chief Medical Officer (CMO) available via YouTube.

Validation of Network Adequacy

During FY 2019–2020, RMHP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. RMHP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

DentaQuest

Due to FY 2019–2020 being the first full year of the DentaQuest contract, there were no FY 2018–2019 required actions or recommendations for follow-up.

Appendix A. CHP+ MCO Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for HEDIS 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2020 hybrid rate.

Table A-1—HEDIS 2020 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Childhood Immunization Status			
Combination 2	82.26%	82.26%	≥90th
Combination 3	82.26%	82.26%	≥90th
Combination 4	82.26%	82.26%	≥90th
Combination 5	79.03%	79.03%	≥90th
Combination 6	59.68%	59.68%	≥90th
Combination 7	79.03%	79.03%	≥90th
Combination 8	59.68%	59.68%	≥90th
Combination 9	58.06%	58.06%	≥90th
Combination 10	58.06%	58.06%	≥90th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	86.71%	87.34%	75th–89th
Combination 2 (Meningococcal, Tdap, HPV)	53.80%	53.80%	≥90th

Table A-2 shows FHP's rates for HEDIS 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2020 hybrid rate.

Table A-2—HEDIS 2020 Administrative and Hybrid Performance Measure Results for FHP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Childhood Immunization Status			
Combination 2	0.00%	53.33%	<10th
Combination 3	0.00%	53.33%	<10th
Combination 4	0.00%	43.33%	<10th
Combination 5	0.00%	40.00%	<10th
Combination 6	0.00%	36.67%	25th–49th
Combination 7	0.00%	36.67%	<10th
Combination 8	0.00%	33.33%	25th–49th
Combination 9	0.00%	26.67%	10th–24th
Combination 10	0.00%	26.67%	10th–24th

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	41.94%	41.94%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	8.06%	8.06%	<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	27.27%	48.13%	<10th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	8.17%	34.65%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	13.69%	41.56%	<10th
Counseling for Nutrition—Total	5.38%	44.99%	<10th
Counseling for Physical Activity—Total	1.96%	35.94%	<10th