CHP+

Child Health Plan *Plus*

FY 2020–2021 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

Background

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, included provisions to implement the Children's Health Insurance Program (CHIP), a program funded jointly by the state and federal governments. Child Health Plan *Plus* (CHP+) is Colorado's implementation of federal CHIP regulations. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), required CHIP managed care organizations (MCOs) to comply with Medicaid managed care regulations set forth by the BBA. In May 2016, the final Medicaid and CHIP Managed Care Regulations articulated in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 cross referenced in 42 CFR Part 457, brought consistency between the Medicaid and CHIP regulations. The final rule requires states that contract with CHIP MCOs and prepaid ambulatory health plans (PAHPs) (collectively referred to as "health plans") for the administration of CHIP programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality and timeliness of, and access to, services provided by the contracted health plans. To meet these requirements, the Colorado Department of Health Care Policy and Financing (the Department) has contracted with Health Services Advisory Group, Inc. (HSAG). The latest reauthorization of CHIP Managed Care Regulations occurred in 2018.

HSAG recognizes that EQR-related activities in fiscal year (FY) 2020–2021 were conducted during the unprecedented coronavirus disease 2019 (COVID-19) pandemic; therefore, results and recommendations, particularly in the access to care domain, should be considered with caution. Regardless, while some health plans experienced lower scores across domains of care, Colorado's CHP+ health plans also found innovative and creative ways to address barriers to providing a quality product for Colorado's CHP+ members.

Colorado's CHP+ Program

The Department contracts with five MCOs that provide physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care, and one PAHP that provides dental services. Colorado does not exempt any of its CHIP health plans from EQR. Table 1-1 lists Colorado's CHP+ health plans.

Table 1-1—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

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the Centers for Medicare & Medicaid Services (CMS) EQR Protocols released in October 2019.[1-1] In FY 2020–2021, HSAG conducted both mandatory and optional EQR-related activities. The mandatory activities conducted were:

- **Validation of performance improvement projects (PIPs) (Protocol 1).** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.
- **Validation of performance measures—HEDIS methodology (Protocol 2).** 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.
- **Assessment of compliance with CHIP managed care regulations (compliance with regulations) (Protocol 3).** 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 four standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of network adequacy (Protocol 4).** Each quarter, HSAG validated each CHP+ health plan's self-reported compliance with minimum time and distance requirements and collaborated with the Department to update the quarterly network adequacy reporting materials used by the CHP+ health plans.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 26, 2021.

The optional activity conducted for the CHP+ health plans was:

- **CAHPS surveys (Protocol 6).** HSAG conducted CAHPS surveys and reported results for all CHP+ health plans on behalf of the Department.

Summary of FY 2020–2021 Statewide Performance by External Quality Review Activity With Trends

Validation of Performance Improvement Projects

Table 1-2 summarizes PIP performance for each CHP+ health plan in FY 2020–2021. Table 1-2 also summarizes how far through the four modules of the rapid-cycle PIP process each CHP+ health plan progressed.

Table 1-2—Statewide PIP Results for CHP+ Health Plans

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

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2020–2021 validation cycle.*

During this validation cycle, the CHP+ health plans initiated new PIPs. All six CHP+ health plans completed Module 1, and five of the six health plans completed and passed Module 2, for the rapid-cycle PIP process. The remaining health plan, FHP, initiated Module 2 but did not pass this module until the next fiscal year. During FY 2020–2021, the CHP+ health plans received training and technical assistance on the rapid-cycle PIP process, supporting the CHP+ health plans in developing the foundation of the projects in the first two modules of the process. The duration of the rapid-cycle PIPs is approximately 18 months, from initial submission of the first module through completion of the fourth and final module; therefore, the PIPs initiated in FY 2020–2021 continued into FY 2021–2022.

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

Although all CHP+ health plans successfully completed Module 1 and five of six CHP+ health plans completed Module 2 of the new rapid-cycle PIPs during FY 2020–2021, HSAG identified two statewide opportunities for improvement while validating these modules and providing technical assistance. First, HSAG observed variation in the quality improvement (QI) capacity, skills, and resources available to PIP teams across the different health plans. While some health plans were able to readily apply the rapid-cycle PIP QI tools and processes to support PIP initiation and intervention determination activities, other health plans required more extensive technical assistance and took longer to progress through the modules. The longer a health plan takes to pass the first three modules of the rapid-cycle PIP progress, the less time remains for the health plan to test interventions and work toward achieving improvement goals. To address this opportunity for improvement, HSAG recommends that the Department work with the health plans to support adequate QI capacity, skills, and resources for each health plan to support current and future PIPs.

A second opportunity for improvement was identified specifically related to the new PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen,* which was mandated by the Department for all CHP+ health plans except DentaQuest. During the FY 2020–2021 validation of modules 1 and 2, HSAG noted that many health plans reported challenges in accessing accurate and complete administrative data from providers on depression screening and behavioral health follow-up services. Health plans reported that they must first address the data accuracy and completeness to determine true performance levels before working on interventions to improve performance. HSAG recommends that the Department work with the health plans to identify specific high-impact barriers to collecting and distributing accurate and complete data and work collaboratively toward solutions for those barriers.

Validation of Performance Measures

Information Systems Standards Review

HSAG reviewed the Final Audit Reports (FARs) produced by each health plan's NCQA-certified HEDIS compliance auditor (CHCA). Each FAR included the auditor's evaluation of the health plan's information systems (IS) capabilities for accurate HEDIS reporting. For the current reporting period, COA, DHMP, FHP, Kaiser, RMHP, and DentaQuest were fully compliant with all IS standards relevant to the scope of the performance measure validation (PMV) performed by the health plans' licensed HEDIS auditors. During review of the IS standards, the licensed HEDIS auditors 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 1-3 and Table 1-4 display the CHP+ statewide weighted averages for HEDIS measurement year (MY) 2018 through HEDIS MY 2020, along with the percentile ranking for each HEDIS MY 2020 rate for the high- and low-performing measure rates. Statewide performance measure results for HEDIS MY 2020 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2019, when available. Rates for HEDIS MY 2020 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS MY 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. Measure rates for individual health plans can be found in Section 3.

Table 1-3—Colorado CHP+ Statewide Weighted Averages—HEDIS MY 2020 High-Performing Rates

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 5	59.76%	54.80%	64.18%^	50th–74th
Combination 6	45.31%	46.77%	55.09%^	75th–89th
Combination 7	58.20%	53.94%	62.62%^	50th–74th
Combination 8	44.29%	45.91%	53.80%^	75th–89th
Combination 9	42.27%	42.44%	51.97%^	75th–89th
Combination 10	41.39%	41.97%	50.95%^	75th–89th
Immunizations for Adolescents				
Combination 2 (Meningococcal, Tdap, HPV)	39.02%	39.20%	42.47%^	50th–74th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.04%	0.04%	0.05%	≥90th
Respiratory Conditions				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	72.63%	72.27%	75th–89th
Asthma Medication Ratio				
Ages 5 to 11 Years	82.63%	88.44%	84.04%	≥90th
Ages 12 to 18 Years	71.32%	70.21%	77.96%	≥90th

[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 MY 2019 rates may be understated or overstated.

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	23.83	24.91	16.07	≥90th
Antibiotic Utilization*				
*Average Scripts PMPY** for Antibiotics—Total*	0.33	0.34	0.23	≥90th
Average Scripts PMPY for Antibiotics of Concern—Total	0.11	0.11	0.07	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	31.91%	32.33%	30.09%	≥90th

** For this indicator, a lower rate indicates better performance.*
*** PMPY = per member per year.*
— Indicates that NCQA recommended a break in trending for HEDIS MY 2019; therefore, the HEDIS MY 2018 rate is not displayed.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

The HEDIS MY 2020 statewide weighted averages for the *Childhood Immunization Status—Combinations 5 through 10* and *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicators within the Pediatric Care domain demonstrated strong performance, as all measure rates statistically significantly improved in HEDIS MY 2020.

The HEDIS MY 2020 statewide weighted average and rates for four of the 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.

The HEDIS MY 2020 statewide weighted average for the *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years* measure indicators in the Respiratory Conditions domain 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).

Although measures within the Use of Services domain were identified as high-performing rates, the rates do not indicate the quality and timeliness of, or access to, care and services. Therefore, caution should be exercised when connecting these data to the efficacy of the program, as many factors influence these data.

Table 1-4—Colorado CHP+ Statewide Weighted Averages—HEDIS MY 2020 Low-Performing Rates

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	73.33%	74.81%	76.12%	10th–24th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total*[1]	22.71%	22.62%	24.29%	<10th
Counseling for Nutrition—Total	21.46%	20.77%	22.75%	<10th
Counseling for Physical Activity—Total	17.58%	16.17%	17.76%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	36.52%	37.26%	35.29%	<10th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD** Medication[1]				
Initiation Phase	15.21%	14.98%	36.45%^	10th–24th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	59.87%	**44.44%^^**	<10th
Cholesterol Testing—Total	—	39.47%	**25.31%^^**	<10th
Blood Glucose and Cholesterol Testing—Total	38.98%	36.84%	**25.31%^^**	10th–24th
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits—Total	195.91	213.53	167.24	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	0.88	0.92	0.68	<10th
Total Average Length of Stay (Total Inpatient)	3.51	3.48	3.15	<10th
Total Discharges per 1,000 Member Months (Medicine)	0.63	0.68	0.51	<10th
Total Average Length of Stay (Medicine)	2.89	2.83	3.13	<10th
Total Discharges per 1,000 Member Months (Surgery)	0.21	0.21	0.15	<10th
Total Average Length of Stay (Surgery)	5.50	5.63	3.34	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.07	0.07	0.05	<10th
Total Average Length of Stay (Maternity)	2.49	3.19	2.55	10th–24th
Antibiotic Utilization***				
Average Days Supplied per Antibiotic Script—Total	16.86	15.10	11.47	<10th

** BMI = body mass index.*
*** ADHD = attention-deficit/hyperactivity disorder.*
**** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS MY 2020 and prior years be considered with caution.
— Indicates that NCQA recommended a break in trending for HEDIS MY 2019; therefore, the HEDIS MY 2018 rate is not displayed.
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.

With the Pediatric Care domain, the HEDIS MY 2020 statewide weighted average for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator fell below the 25th percentile, demonstrating an opportunity for improvement. Additionally, the *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* measure indicators fell below the 10th percentile.

Within the Preventive Screening domain, the statewide weighted average fell below the 10th percentile for the *Chlamydia Screening in Women—Ages 16 to 20 Years* measure indicator, indicating opportunities exist to increase screenings for chlamydia for young women.

The measures determined to be low-performing rates for HEDIS MY 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 on a small population of members prescribed medications for behavioral health conditions.

Although measures within the Use of Services domain were identified as low-performing rates, the rates do not indicate the quality and timeliness of, or access to, care and services. Therefore, caution should be exercised when connecting these data to the efficacy of the program, as many factors influence these data.

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

The health plans' HEDIS compliance FARs indicated that all health plans followed the 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.

Statewide performance for HEDIS MY 2020 demonstrated opportunities to improve rates related to preventive care and services for members, including well-care visits, immunizations, chlamydia screening, follow-up care for members prescribed ADHD medications, and monitoring for children and adolescents on antipsychotics. All three indicators for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure had a statistically significant decline in performance from the previous year and all three fell below the 25th percentile. HSAG recommends that the Department and the MCOs work together to identify barriers for members getting tested (e.g., determine whether the COVID-19 public health emergency created barriers for metabolic testing). Additionally, HSAG recommends that the Department and the MCOs do the following to ensure proper metabolic testing is completed for members:

- Educate members on the importance of consistent testing.
- Ensure members have the appropriate transportation to and from appointments.
- Monitor members' weight and blood pressure to identify significant changes.
- Coordinate care between the members' primary care providers (PCPs) and behavioral health providers.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2020–2021, HSAG reviewed four standards as directed by the Department (see Section 2—Reader's Guide, Methodology). To assist the CHP+ health plans with understanding 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 1-5 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.[1-3]

Table 1-5—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 (Includes Confidentiality) (2015–2016, 2018–2019)	80%	90%
Standard V—Member Information (2017–2018, 2020–2021)	**95%**	**84%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**84%**	**79%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**90%**	**91%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	94%	97%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	**79%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	88%	87%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

[1-3] In FY 2020–2021 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.

Colorado's CHP+ health plans demonstrated high scores (90 percent compliance or higher) in four of the 10 standards and three of the five record review topics. Notably, health plans demonstrated high levels of compliance with credentialing and recredentialing requirements, which averaged 97 percent compliance, and record review scores reached 99 and 100 percent compliance, respectively, across the CHP+ health plans during FY 2018–2019. During the FY 2020–2021 review period, health plans received the highest scores related to Standard VII—Provider Participation (Selection) and Program Integrity, which reached 91 percent compliance. See Section 4, Table 4-3 for additional details.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

Three standards fell below 80 percent compliance within the previous three-year review cycle: Standard I—Coverage and Authorization of Services, Standard VI—Grievance and Appeal Systems, and Standard IX—Subcontractual Relationships and Delegation. The lowest scoring standard was Standard I—Coverage and Authorization of Services during the FY 2019–2020 reviews. During the FY 2020–2021 review period, the two lowest scoring standards both reached only an average of 79 percent compliance.

Related to grievances and appeals, HSAG recommends that health plans engage in periodic review of regulations to ensure policies and procedures are current, and ensure that updates are carried forward to desktop procedures and training materials. Additionally, HSAG recommends that health plans engage in ongoing efforts for appeal and grievance staff members to ensure member acknowledgement and resolution letters are written in member-friendly language.

Related to Standard IX—Subcontractual Relationships and Delegation, HSAG recommends the health plans update template contracts as well as amend existing delegate agreements to include the required federal language.

Validation of Network Adequacy

Results

HSAG collaborated with the Department to update quarterly network adequacy reporting materials originally implemented in January 2020. Each quarter, the CHP+ health plans used the standardized templates to report narrative descriptions and geoaccess compliance results for time and distance analysis and ratios of practitioners to members. HSAG conducted quarterly network adequacy validation (NAV) analyses of the CHP+ networks among the following domains for the CHP+ health plans:

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

The data-related findings in this report align with HSAG's validation of the CHP+ health plans' FY 2020–2021 Quarter 2 network adequacy reports, representing the measurement period reflecting the CHP+ health plans' networks from October 1, 2020, through December 31, 2020.

Overall, no CHP+ health plan met all network standards across all counties in each county designation. In general, failure to meet the minimum time and distance network requirements was largely attributable to instances in which the closest network locations were outside the minimum time and distance requirement. However, for a CHP+ health plan to meet the minimum network requirements outlined in its contract with the Department, the health plan must ensure that its network is such that 100 percent of its enrolled members have addresses within the minimum network requirements (i.e., a 100 percent access level). For example, the CHP+ health plans in urban counties (e.g., Denver County) must ensure that at least two family practitioners are within 30 miles or 30 minutes of 100 percent of each of the health plan's applicable members. As a result, a health plan's failure to meet a minimum network requirement does not necessarily reflect a network concern, and the health plan may employ alternate methods for ensuring members' access to care (e.g., the use of telehealth).

Network adequacy analysis results for DentaQuest were similar to those obtained for the CHP+ MCOs. The PAHP did not meet all network standards across all counties in each county designation. The PAHP met a higher percentage of minimum time and distance network requirements in urban counties as compared to rural and frontier counties. HSAG agreed with 100 percent of the PAHP's reported FY 2020–2021 Quarter 2 geoaccess compliance results for frontier counties, 98.1 percent of reported results for rural counties, and 82.1 percent of reported results for urban counties.

To facilitate the Department's use of the quarterly NAV results, HSAG collaborated with the Department to develop and deploy web-based interactive dashboards displaying and stratifying NAV results by health plan, network category, and county. Furthermore, the Department responded to the results of the FY 2020–2021 NAV analysis by implementing the following QI efforts in collaboration with HSAG during FY 2021–2022:

- Develop and implement web-based dashboards to supply detailed network data quality results to each health plan, to support improved network data quality.
- Use the health plans' quarterly NAV reports and data to reevaluate the minimum time and distance network requirements.
- Review and update the processes and templates by which the health plans may request that the Department grant an exception to minimum network requirements.

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

Based on the quarterly NAV results for the CHP+ health plans, HSAG offers the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the health plans' compliance with network adequacy contract requirements and the provision of high-quality network data:

- **Enhance Network Data Quality**: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. Each health plan will be expected to use the detailed data quality results to improve the quality of their quarterly member and network data submissions to the Department.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the health plans' networks through the development and implementation of standardized quarterly network adequacy reporting materials. The Department has directed its EQRO to conduct the following activities during FY 2021–2022:
  - An evaluation of the existing process(es) by which the health plans are directed to request and receive exceptions to network requirements. If supported by the evaluation findings, the Department may consider standardizing the health plan exception request documentation and processes to ensure uniform review and documentation of the health plans' network exceptions.
  - An evaluation of the appropriateness of the minimum time and distance network requirements in the health plans' contracts with the Department. The evaluation may also consider the extent to which the health plans offer alternate service delivery mechanisms to ensure members' access to care when minimum time or distance requirements may not be appropriate based on the geography and/or network category. For example, the Department may consider the extent to which a health plan offers and ensures that members are able to use telehealth modalities to obtain behavioral health services when practitioners are not available in rural or frontier counties.
- **Expand Network Adequacy Evaluation**: To further assess network availability, the Department should review ways to evaluate the health plans' compliance with contract network requirements for access to care, including the following:
  - Future access to care evaluations may incorporate the health plans' encounter data to assess members' utilization of services and potential gaps in access to care resulting from limited network availability.
  - The Department may also consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data available to the health plans' members and align with the network data supplied to the Department for the quarterly network adequacy compliance reporting.
  - In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department may choose to review member satisfaction survey results and grievance and appeals data to identify results and complaints related to members' access to care. Survey results and grievance and appeals data may then be used to evaluate the degree to which

members are satisfied with the care they have received and the extent to which unsatisfactory care may be related to a health plan's limited network availability.

CAHPS Surveys

Table 1-6 shows the statewide aggregate rate results (i.e., combined results of the five CHP+ MCOs) for each CAHPS measure for FY 2018–2019 through FY 2020–2021.[1-4]

Table 1-6—Top-Box Scores for the Statewide Aggregate Rate

Measure	FY 2018–2019 Statewide Aggregate Score	FY 2019–2020 Statewide Aggregate Score	FY 2020–2021 Statewide Aggregate Score
Getting Needed Care	87.1%	83.7%	80.1%
Getting Care Quickly	90.5%	90.9%	86.6% ▼
How Well Doctors Communicate	95.4%	97.5%	94.1% ▼
Customer Service	84.0%	82.3%	87.2%
Rating of Health Plan	67.1%	63.3%	67.0%
Rating of All Health Care	67.1%	68.8%	72.7%
Rating of Personal Doctor	76.6%	77.6%	77.4%
Rating of Specialist Seen Most Often	77.9%	71.6%	69.6%

▲ *Indicates the FY 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Over the three-year period, one measure, *Rating of All Health Care*, showed an upward score trend. Conversely, the *Getting Needed Care* 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. The statewide aggregate rate was not statistically significantly higher in FY 2020–2021 than in FY 2019–2020 on any measure. The statewide aggregate rate was statistically significantly lower in FY 2020–2021 than in FY 2019–2020 on two measures: *Getting Care Quickly* and *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, two measures related to the quality and timeliness of care domains (*How Well Doctors Communicate* and *Getting Care Quickly*) experienced a statistically

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

significant decrease from FY 2019–2020 to FY 2020–2021. Performance for the *Getting Care Quickly* measure assesses whether parents/caretakers feel their child received the services and appointments they needed in a timely manner, but also may be related to a variety of additional factors. Performance for the *How Well Doctors Communicate* measure assesses whether parents/caretakers feel their child's primary doctor explained things in an understandable way, but may be related to a variety of additional factors, including whether caretakers fell that the provider listened carefully, showed respect, and spent enough time with them. HSAG recommends that the Department explore what may be driving a decrease in the scores for these measures from FY 2019–2020 to FY 2020–2021 and develop initiatives for improvement, where appropriate.

For additional information about CHP+ CAHPS results for FY 2020–2021, refer to the CHP+ aggregate CAHPS report found on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

Colorado's CHP+ Managed Care Quality Strategy

Colorado's CHP+ program offers comprehensive healthcare benefits to two populations: 1) uninsured children, ages 18 and younger, and 2) pregnant women who do not qualify for Health First Colorado but cannot afford private health insurance. Colorado provides services through five regionally-based MCOs and one dental PAHP serving CHP+ members throughout the state collectively referred to as "health plans."

The Department assesses and evaluates performance of the program through requiring its health plans to conduct the following:

- Ongoing assessments of quality and appropriateness of care.
- Calculating and reporting national performance measures such as HEDIS and CAHPS.
- Internal auditing and monitoring to detect fraud, waste, and abuse.
- Regular monitoring of the health plans' compliance programs.
- Participation in mandatory EQR activities.

The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve the quality, timeliness of, and access to care based on the Department's strategic QI goals and associated objectives. Based on EQR findings for FY 2020–2021, HSAG recommends the following to target and improve statewide performance and achieve selected goals and objectives.

Goals, Objectives, and Statewide Recommendations

Goal 1: Enhancing the Delivery System

Objectives

- Improving the members' experience of patient care.
- Promoting effective prevention and treatment of chronic disease by ensuring members are connected to the right care, at the right time, every time.
- Increasing and monitoring members' access to care and provider network adequacy.

Recommendations

- Encourage its health plans to engage in a targeted assessment of its customer service functions. This department within a health plan is typically the first contact point for members and may directly impact member perceptions of the quality of the health plan. Initiatives designed to improve customer service interactions may impact several measures related to quality and access to care.
- Encourage its health plans to assess utilization review turnaround times and communications to members related to utilization review processes. Members' perceptions of authorization processes and timeliness of authorizations may impact measures related to quality and timeliness of services provided.
- Encourage its health plans to invest in more creative and robust care coordination programs that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions, and assess and refer members to appropriate community partners to address social determinants of health.
- Continue to critically evaluate and refine network adequacy oversight and enhance Colorado-specific minimum network requirements to reflect Colorado's healthcare delivery system and unique geography.
- Encourage health plans to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters, to improve member understanding and engagement in healthcare and the healthcare community.

Goal 2: Improving Population Health

Objectives

- Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.
- Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care.

Recommendations

- Continue to strengthen community partnerships and encourage health plans to continue to invest in the health neighborhood.
- Use the Department's integrated quality improvement committee (IQuIC) as a forum in which the higher performing MCOs share best practices for identifying QI goals, objectives, and interventions, as well as to collaborate on program-wide solutions to common barriers.

Goal 3: Reducing Per Capita Costs of Healthcare

Objectives

- Deliver high quality of care.
- Improve the quality of data used for performance metrics and monitoring.
- Implement pay for performance.

Recommendations

- Consider CHP+ value-based payment program.
- Evaluate the accuracy of the health plans' encounter data and encourage health plans to conduct ongoing quality monitoring of encounter data accuracy.
- Continue to collaborate with the health plans to support adequate QI capacity, skills, and resources for each MCO and the PAHP to support current and future PIPs.
- Formalize health plan monitoring by conducting routine health plan-specific performance review meetings that utilize formal and informal verbal and written expectation setting, performance review, and health plan response to support monitoring efforts to improve performance on targeted objectives in selected performance metrics.

2. Reader's Guide

Report Purpose and Overview

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, the Department contracts with HSAG to annually provide to CMS an assessment of the State's CHP+ health plans' performance, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that HSAG conducted with the CHP+ health plans throughout FY 2020–2021.

How This Report Is Organized

Section 1—Executive Summary includes a brief introduction to the CHP+ program and describes the authority under which the report must be provided, as well as the EQR activities conducted during FY 2020–2021with a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQR activities in FY 2020–2021. This section also includes a summary description of relevant statewide trends over a three-year period for each EQR activity as applicable, with references to the section in which 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, as well as an assessment of how the Department can target the goals and objectives of the State's Managed Care Quality Strategy to better support the improvement of the quality and timeliness of, and access to healthcare provided by the CHP+ health plans.

Section 2—Reader's Guide provides the purpose and overview of this annual EQR technical report; an overview of the methodology for each EQR activity performed; and how HSAG obtained, aggregated, and used the data obtained to draw conclusions as to the quality and timeliness of, and access to care provided by Colorado's CHP+ health plans.

Section 3—Evaluation of Colorado's CHP+ Health Plans provides summary-level results for each EQR activity performed for the CHP+ health plans in FY 2020–2021. This information is presented for each health plan and provides an activity-specific assessment of the quality and 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.

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.

Validation of Performance Improvement Projects

Objectives

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

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

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

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

Technical Methods of Data Collection

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

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

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the health plan sets aims (Global and SMART [Specific, Measurable, Attainable, Relevant, Time-bound]), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.
- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the QI activities reasonably expected to impact the SMART Aim. The health plan updates the key driver diagram from Module 1 after completing process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking for a more in-depth understanding of the improvement strategies that are most likely to support achievement of the SMART Aim goal.
- **Module 3—Intervention Testing:** In Module 3, the health plan defines the intervention plan for the intervention to be tested, and the intervention effectiveness measure and data collection process are defined. The health plan will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, the health plan summarizes key findings, compares successful and unsuccessful interventions, and reports outcomes achieved. The health plan will synthesize data collection results, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement after the project ends.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission forms. In FY 2020–2021, these forms provided detailed information on the PIPs and the activities completed for Module 1—PIP Initiation and Module 2—Intervention Determination.

Following HSAG's rapid-cycle PIP process, the health plans submitted each module according to the approved timeline. Following the initial validation of each module, HSAG provided feedback and technical assistance to the health plans, and the health plans resubmitted revised modules 1 and 2 until all validation criteria were achieved.

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

Table 2-1—FY 2020–2021 CHP+ PIP SMART Aim Statements and Data Sources

Health Plan	SMART Aims	Data Sources
COA	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.40% to 41.16%.	Claims and enrollment data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 63.64% to 83.64%.	Claims and enrollment data
DHMP	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH [patient-centered medical home], from 68.46% to 76.15%.	Enrollment data, claims data, and electronic medical record (EMR) data
	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH from 46.43% to 75.00%.	Enrollment data, claims data, and EMR data
FHP	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to increase the percentage of CHP+ members ages 12–17 years of age to have the correct coding by the provider when receiving a depression screening during their outpatient visit from 2% to 16%.	Claims and enrollment data
	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to maintain the percentage of CHP+ members ages 12–17 years of age who receive a follow-up visit within 30 days of the positive depression screening at 90% or higher.	Claims and enrollment data
Kaiser	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs [medical office buildings] between the ages 12 and 17 who are screened for depression annually from 9.93% to 20%. This will be achieved by utilizing key driver diagram interventions.	Enrollment and EMR data
	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12-17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.	Enrollment and EMR data

Health Plan	SMART Aims	Data Sources
RMHP	By 6/30/2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP Members 12 years of age or older from 3.5% to 25.0%.	Claims and enrollment data
	By 6/30/2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP Members 12 years of age or older who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days to the established benchmark of 46.89%.	Claims and enrollment data
DentaQuest	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members aged 3–5 who reside in Weld County, from 45.47% to 49.3%.	Claims and enrollment data

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

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 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-4]

During validation, HSAG determined if criteria for each module were *Met*. Any validation criteria not applicable were not scored. As the PIP progresses, and at the completion of Module 4, HSAG will use the validation findings from modules 1 through 4 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 26, 2021.

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

To draw conclusions about the quality 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. The Department selected the state-mandated PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*, for all health plans, except DentaQuest. In addition to addressing the quality domain, the state-mandated topic (access to depression screening and follow-up behavioral health services) addressed access to care and timeliness of care

(receiving timely follow-up behavioral health services after a positive depression screen). DentaQuest selected a different topic relevant to the scope of services it provides as a dental PAHP, which also addressed access to dental care, in addition to addressing the quality domain. The assignment of domains for each PIP is shown in Table 2-2.

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

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

Validation of Performance Measures

Objectives

The primary objectives of the 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 a 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

[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: Oct 26, 2021.

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 MY 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 the audit reports produced by the other licensed audit organizations. Through review of each health

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

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, the following key types of data were obtained and reviewed for HEDIS MY 2020 as part of the validation of performance measures:

1. **FARs:** The FARs, produced by the health plans' LOs, provided information on the health plans' compliance to IS standards and audit findings for each measure required to be reported.
2. **Measure Certification Report:** The vendor's measure certification report was reviewed to confirm that all required measures for reporting had a "pass" status.
3. **Rate Files from Previous Years and Current Year:** Final rates provided by health plans in IDSS format were reviewed to determine trending patterns and rate reasonability.

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 MY 2018, HEDIS MY 2019, and HEDIS MY 2020 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for HEDIS MY 2018, HEDIS MY 2019, and HEDIS MY 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.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the audited HEDIS results submitted to the Department by the five CHP+ MCOs and the one dental PAHP (collectively referred to as "health plans"), which included each health plan's FAR and IDSS, or custom rate reporting template if an IDSS file was not available. HSAG used the final audit results and the FAR as the primary data sources to tabulate overall HEDIS reporting capabilities and functions for the health plans. The final audit results provided the final determinations of validity made by the health plan's LO auditor for each performance measure. The FAR included information on the health plan's IS capabilities, findings for each measure, MRR validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement.

The health plans' 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.[2-7] 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

[2-7] DentaQuest was required to calculate and report dental services-specific rates; therefore, DentaQuest rates are not included in any statewide rates.

Measure results for HEDIS MY 2020 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2019. 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 health plans to report this rate for the respective HEDIS submission or NCQA recommended a break in trending in HEDIS MY 2020. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS MY 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-performing rates are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the 75th percentile without a statistically significant decline in performance from HEDIS MY 2019.
  - Ranked between the 50th and 74th percentiles with statistically significant improvement in performance from HEDIS MY 2019.
- Low-performing rates are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Ranked below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with statistically significant decline in performance from HEDIS MY 2019.

Based on 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 MY 2018, HEDIS MY 2019, and HEDIS MY 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 2-3 presents the measures provided in the report that can be reported using the hybrid methodology.

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

HEDIS Hybrid Measures
Pediatric Care
Childhood Immunization Status
Immunizations for Adolescents

HEDIS Hybrid Measures
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Access to Care
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 indicators reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 2-4.

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

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Immunizations for Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Access to Care			
*Prenatal and Postpartum Care**	✓	✓	✓
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	✓		
Asthma Medication Ratio	✓		

Performance Measure	Quality	Timeliness	Access
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+ State Managed Care Network (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).

Assessment of Compliance With CHIP Managed Care Regulations

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

Table 2-5—Compliance Standards

Standard Number and Title	Regulations Included
Standard I—Coverage and Authorization of Services	438.114 438.210
Standard II—Access and Availability	438.206 438.207
Standard III—Coordination and Continuity of Care	438.208
Standard IV—Member Rights and Protections (Includes Confidentiality)	438.100 438.224
Standard V—Member Information	438.10
Standard VI—Grievance and Appeal Systems	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424
Standard VII—Provider Participation (Selection) and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610

Standard Number and Title	Regulations Included
Standard VIII—Credentialing and Recredentialing	NCQA Credentialing and Recredentialing Standards and Guidelines
Standard IX—Subcontractual Relationships and Delegation	438.230
Standard X—Quality Assessment and Performance Improvement	438.236 438.240 438.242
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	441.50 441.62 10 Code of Colorado Regulations (CCR) 2505, 8.280
Standard XII—Enrollment and Disenrollment	438.3(d) 438.56

For the FY 2020–2021 compliance review process, the standards reviewed were Standard V—Member Information, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation (Selection) and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. 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 grievances and appeals received by the health plan during the review period.

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.

HSAG HEALTH SERVICES ADVISORY GROUP

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.[2-8] Table 2-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

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

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Due to the COVID-19 pandemic, the Department directed HSAG to conduct all compliance monitoring activities virtually. HSAG used Webex conferencing to conduct the FY 2020–2021 compliance reviews. All protocol activities, requirements, and agendas were followed. Before the virtual compliance review designed to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates and virtual review agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's 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 Webex portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and a virtual review 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 virtual review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the virtual portion of the review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of

[2-8] 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 29, 2020.

For this step,	HSAG completed the following activities:
	all grievances and appeals filed between January 1, 2020, and December 31, 2020 (to the extent available at the time of the virtual review). HSAG used a random sampling technique to select records for review. • The HSAG review team reviewed all documentation submitted prior to the Webex portion of the review and prepared a request for further documentation, if needed, as well as an interview guide for HSAG's use during the review.
Activity 3:	**Conduct Virtual Compliance Review**
	• During the Webex 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. • HSAG also requested and reviewed additional documents as needed, based on interview responses. • At the close of the Webex portion of the review, HSAG met with the health plan's staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the compliance review report template to compile the findings and incorporate information from all compliance review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the compliance review report to the health 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 (grievances and appeals)
- Interviews with key health plan staff members conducted virtually

How Data Were Aggregated

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, the review of credentialing records provided by the health plan, virtual interviews conducted with key health plan personnel, and any additional documents submitted as a result of the interviews. HSAG then calculated scores; analyzed scores, looking for patterns of compliance and noncompliance; and compared scores to the health plans' previous performance, looking for trends. HSAG developed statewide tables of performance (see Section 4) to conduct comparisons of health plans and determine if commonalities of performance existed within the review period, and developed long-term comparison of standard scores over the three-year cycle to determine if the health plans' overall compliance improved across multiple review cycles.

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 2-7 depicts assignment of the standards to the domains of care.

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

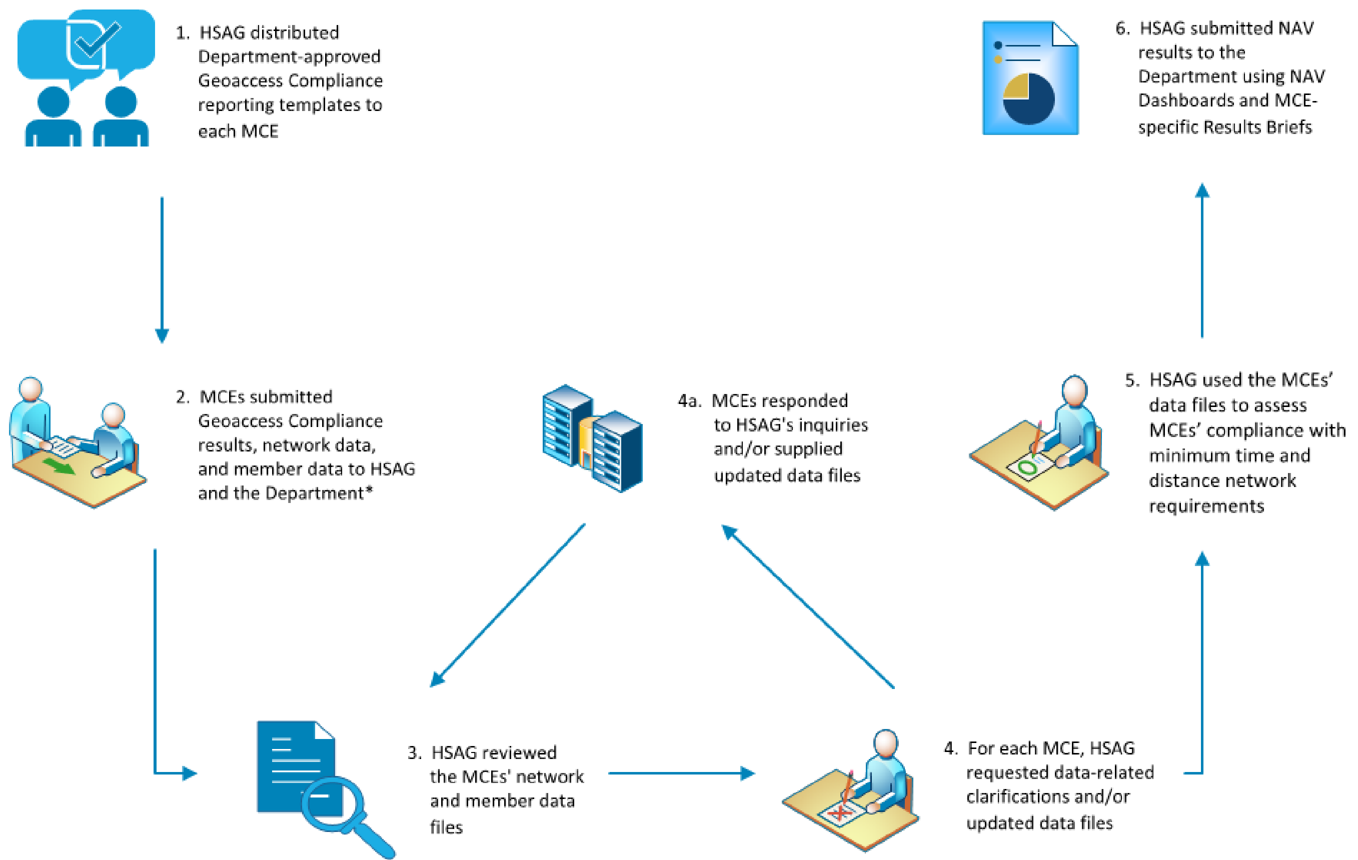
Compliance Review Standard	Quality	Timeliness	Access
Standard V—Member Information	✓		✓
Standard VI—Grievance and Appeal Systems	✓	✓	
Standard VII—Provider Participation (Selection) and Program Integrity	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		✓

Validation of Network Adequacy

Objectives

The purpose of the FY 2020–2021 NAV was to determine the extent to which HSAG agreed with the health plans' (also referred to as "managed care entities [MCEs]" for the NAV activity) self-reported compliance with minimum time and distance network requirements applicable to each health plan. Beginning in the upper left corner, Figure 2-1 describes HSAG's three main phases for the FY 2020–2021 NAV process.

Figure 2-1—Summary of FY 2020–2021 Network Adequacy Validation Process



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

HSAG provided the Department-approved geoaccess compliance templates and requested network and member data from each health plan. HSAG reviewed each health plan's network and member data, iteratively requesting clarifications of data-related questions or updated data files. Once clarified and updated as needed, HSAG performed the network adequacy analyses to assess health plan compliance

with minimum time and distance standards. HSAG also developed the network adequacy dashboards for internal use by the Department in QI activities.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the quarterly network adequacy report templates. Analyses and templates included, at a minimum, network categories aligned with the Department's managed care Network Crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[2-9,2-10] Table 2-8 presents the network domains applicable to CHP+ health plans; within each domain, network categories included in the FY 2020–2021 NAV analyses were limited to categories corresponding to the health plans' minimum time and distance network requirements.

Table 2-8—Network Domains by Health Plan Type

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

Technical Methods of Data Collection

During FY 2018–2019 and FY 2019–2020, HSAG collaborated with the Department to develop a Network Crosswalk and standardized network adequacy reporting materials, with the goal of standardizing the health plans' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the health plans' network adequacy results. On December 30, 2020, HSAG sent each health plan a reminder notice that included detailed data requirements and a health plan-specific Network Adequacy Quarterly Geoaccess Results Report template containing the health plan's applicable network requirements and contracted counties. To support consistent network definitions across the health plans and over time, HSAG supplied the health plans with the Department-

[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: Jul 30, 2021.

[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.

approved June 2020 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

Concurrent with requesting the health plans' network and member data, HSAG requested CHP+ member files from the Department using a detailed member data requirements document for members actively enrolled with a health plan as of December 31, 2020. During the FY 2020–2021 Quarter 2 NAV, HSAG used the Department's member data to assess the completeness of the health plans' member data submissions (e.g., comparing the number of members by county between the two data sources).

Description of Data Obtained

Quantitative data for the study included member-level data from the Department and member and network data files data from each 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 [LCSW]), and/or taxonomy code.

How Data Were Aggregated

HSAG used the health plans' member and network data to calculate time/distance and compliance mismatch results for each health plan for each county in which the health plan had at least one member identified in the health plan's member data file during FY 2020–2021 Quarter 2. HSAG evaluated two dimensions of access and availability: compliance mismatch (i.e., HSAG did not agree with the health plan's quarterly geoaccess compliance results) and geographic network distribution analysis (i.e., time and distance metrics). HSAG calculated these metrics for the network categories for which the Department identified a minimum time and distance access requirement prior to initiation of the analysis.

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

- Evaluating the extent of missing and invalid data values.
- Compiling the frequencies of data values.
- Comparing the current data to the health plans' prior quarterly data submissions.

HSAG also used the Department's member data to assess the completeness and reasonability of the health plans' member data files (e.g., assessing the proportion of members residing outside of a health plan's assigned counties and comparing the results to prior quarters' data). HSAG supplied each health plan with a written document summarizing the initial file review findings and stating whether clarifications and/or data file resubmissions were required.

Following the initial data review and HSAG's receipt of the MCEs' data resubmissions and/or clarifications, HSAG geocoded the member and network addresses to exact geographic locations (i.e., latitude and longitude). Geocoded member and network data were assembled and used to conduct plan type-specific (MCO or RAE) analyses using the Quest Analytics Suite Version 2020.2 software (Quest). HSAG used Quest to calculate the duration of travel time or physical (driving) distance between the members' addresses and the addresses of the nearest provider(s) for the selected network categories.

Consistent with the Department's instructions to the health plans, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[2-11] HSAG used the counties listed in the health plans' member data files to attribute each member to a Colorado county for the county-level time and distance calculations (i.e., the number and percentage of members residing in the specified county with a residential address within the minimum time or distance requirement for the specific network requirement among all applicable providers, regardless of the providers' county). For health plan member records missing the county information, HSAG used the county identified by Quest if the address was an exact match during the geocoding process. Members that could not be attributed to a Colorado county were excluded from the NAV analyses.

How Conclusions Were Drawn

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

CAHPS Surveys

Objectives

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

Technical Methods of Data Collection

HSAG administered the *CAHPS 5.1 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set (without the Children with Chronic Conditions [CCC] measurement set) for the CHP+ population. Parents/caretakers of child members included as eligible for the survey were 17 years of age or younger as of December 31, 2020. All parents/caretakers of sampled members completed the surveys

[2-11] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2018. Available at: http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2013/10/2018-map.pdf. Accessed on: Jun 3, 2021.

from February to May 2021. The first phase consisted of an English or Spanish version of the cover letter being mailed to the parents/caretakers of all sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. The cover letters included a toll-free number that parents/caretakers could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a second reminder postcard. The second phase, or telephone phase, consisted of computer-assisted telephone interviewing (CATI) of parents/caretakers of sampled child members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent at different times of the day, on different days of the week, and in different weeks.

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

Description of Data Obtained

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

How Data Were Aggregated

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

HSAG performed a trend analysis of the results in which the FY 2020–2021 scores were compared to their corresponding FY 2019–2020 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2020–2021 top-box scores and the FY 2019–2020 top-box scores are noted with directional triangles. Scores that were statistically

significantly higher in FY 2020–2021 than FY 2019–2020 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2020–2021 than FY 2019–2020 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG performed health plan comparisons of the results. Statistically significant differences between the health plans' top-box responses and the statewide aggregate rates are noted with arrows. A health plan's top-box score that was statistically significantly higher than the statewide aggregate rate is noted with an upward green (↑) arrow. A health plan's top-box score that was statistically significantly lower than the statewide aggregate rate is noted with a downward red (↓) arrow. A health plan's top-box score that was not statistically significantly different than the statewide aggregate rate is not denoted with an arrow.

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 CAHPS measures 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 Measure	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	✓		

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2020–2021. 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.

3. Evaluation of Colorado's CHP+ Health Plans

Colorado Access

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-1 and Table 3-2 display the FY 2020–2021 validation findings for COA's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, COA completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, COA defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statements. The SMART aim statements that COA defined for the two PIP outcome measures in Module 1 are provided in Table 3-1.

Table 3-1—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.40% to 41.16%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-Up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 63.64% to 83.64%.

In Module 2—Intervention Determination, COA conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, COA updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by COA in Module 2 are summarized for the two PIP outcome measures in Table 3-2. The PIP had not progressed to the point of deploying and testing interventions. The interventions that COA ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-2—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, COA will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. COA will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

COA: Strengths

The validation findings suggest that COA was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. COA also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

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

As COA continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- COA should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as COA progresses through determining and testing interventions.
- COA should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, COA should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to COA's HEDIS MY 2020 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 3-3 shows the performance measure results for COA for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-3—Performance Measure Results for COA

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	71.58%	72.06%	74.12%	50th–74th
Combination 3	69.58%	70.04%	72.50%	50th–74th
Combination 4	66.86%	68.02%	69.87%	50th–74th
Combination 5	63.21%	61.31%	67.24%^	75th–89th
Combination 6	49.53%	53.22%	58.14%^	≥90th
Combination 7	61.32%	59.92%	65.12%^	75th–89th
Combination 8	48.23%	51.83%	56.32%	75th–89th
Combination 9	45.64%	47.53%	55.11%^	≥90th
Combination 10	44.58%	46.78%	53.69%^	≥90th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	76.30%	76.14%	76.97%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	38.90%	40.19%	41.81%	50th–74th
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	54.92%	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	75.31%	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	47.69%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	9.27%	11.78%	15.33%^	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Counseling for Nutrition—Total	5.11%	6.66%	10.66%^	<10th
Counseling for Physical Activity—Total	3.14%	4.36%	7.62%^	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	32.27%	34.07%	33.74%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.08%	0.00%	0.04%	≥90th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication[1]				
Initiation Phase	0.00%	0.00%	33.78%^	10th–24th
Continuation and Maintenance Phase	NA	NA	46.94%	25th–49th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	60.58%	**40.80%^^**	<10th
Cholesterol Testing—Total	—	33.65%	**19.20%^^**	<10th
Blood Glucose and Cholesterol Testing—Total	30.49%	30.77%	**19.20%^^**	<10th
Respiratory Conditions				
Appropriate Testing for Pharyngitis[1]				
Ages 3 to 17 Years	—	85.48%	83.84%	50th–74th
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	—	92.27%	92.12%	50th–74th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	72.11%	70.30%	75th–89th
Asthma Medication Ratio				
Ages 5 to 11 Years	83.19%	87.60%	84.12%	≥90th
Ages 12 to 18 Years	75.79%	72.92%	72.80%	75th–89th
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	26.90	27.08	17.24	≥90th
Outpatient Visits—Total	218.12	227.68	177.19	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	1.03	1.02	0.73	<10th
Total Average Length of Stay (Total Inpatient)	3.43	3.40	3.30	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Medicine)	0.74	0.76	0.56	<10th
Total Average Length of Stay (Medicine)	2.97	2.82	3.26	10th–24th
Total Discharges per 1,000 Member Months (Surgery)	0.25	0.23	0.15	<10th
Total Average Length of Stay (Surgery)	4.90	5.36	3.54	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.09	0.08	0.06	<10th
Total Average Length of Stay (Maternity)	2.58†	3.43†	2.69†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.35	0.35	0.21	≥90th
Average Days Supplied per Antibiotic Script—Total	10.87	10.70	11.45	<10th
Average Scripts PMPY for Antibiotics of Concern	0.12	0.12	0.07	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.71%	33.07%	30.66%	≥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 HEDIS MY 2020 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 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 MY 2018 or HEDIS MY 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.

COA: Strengths

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

- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*
- *Childhood Immunization Status—Combinations 5*, *6*, *7*, *8*, *9*, and *10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

For HEDIS MY 2020, COA demonstrated strong performance with children receiving vaccinations by ranking above the 50th percentile for all nine *Childhood Immunization Status* measure rates. Additionally, the MCO demonstrated appropriate management of members with asthma and acute bronchitis/bronchiolitis and ensured providers are 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 MY 2020 measure rates were determined to be low-performing rates for COA (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS MY 2019):

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *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*

COA's performance demonstrated opportunities to improve rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators and *Chlamydia Screening in Women—Ages 16 to 20 Years* measure indicator with rates falling 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, impact of COVID-19), and implement strategies to improve the care for young members.

Additionally, COA's rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol—Total*, and *Blood Glucose and Cholesterol Testing—Total* measure indicators fell below the 10th percentile. Antipsychotic medication use is associated with adverse physical side effects (e.g., type 2 diabetes, cardiovascular disease), and children are more at risk for these side effects when they receive multiple antipsychotics.[3-1] COA and the Department should conduct root cause analyses for the low monitoring rates for members prescribed ADHD and/or antipsychotic medications to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care or the need for improved provider training) and implement strategies to improve the care for these members.

[3-1] Correll CU, Detraux J, De Lepeleire J, De Hert M. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*. 2015;14(2):119-36.

Assessment of Compliance With CHIP Managed Care Regulations

COA Overall Evaluation

Table 3-4 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 2020–2021.

Table 3-4—Summary of COA Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	21	20	19	1	0	1	95%
Standard VI—Grievance and Appeal Systems	34	34	30	4	0	0	88%
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	16	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Totals	**75**	**74**	**69**	**5**	**0**	**1**	**93%***

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

Table 3-5 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 2020–2021.

Table 3-5—Summary of COA Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	52	50	2	8	96%
Appeals	60	59	56	3	1	95%
Totals	**120**	**111**	**106**	**5**	**9**	**95%***

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

COA: Strengths

COA submitted policies and procedures, which described the processes and standards used to develop effective communication materials for members. The CHP+ HMO Member Handbook contained information about enrollment, benefits and how to access them, cost sharing, member rights, grievance and appeal processes, advance directives, how to report suspected fraud, and other helpful resource information.

COA demonstrated an internal grievance and appeal system, which managed grievances and appeals in accordance with regulations, as well as collected and tracked information in a systematic way to meet timeliness standards. Policies and procedures contained thorough details and were well-aligned with both federal and State language. Grievance and appeal acknowledgement and resolution letters were 100 percent compliant with timeliness standards, based on record review findings.

COA staff members reported having a long-standing relationship with providers in the Denver-metro area, with ongoing provider relations efforts focused on filling any known specialist gaps.

The compliance committee structure was described as a three-tiered approach, which included the management level, the executive team, and the board of directors for wide-ranging oversight. Compliance committee agenda topics included audits from the previous quarter; privacy and security activities, including a summary of significant issues; and a review of the health plan's risk profile.

Sample delegation agreements included language that COA maintained ultimate responsibility for complying with State contract terms and conditions and CHP+ managed care regulations; provisions for COA to take action, including revocation, if the contracted entity failed to meet its obligations; and language that the delegated entity was required to adhere to CMS and State law, retain records for 10 years, and allow for an audit upon the request of COA or a regulatory body.

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

The "accessibility widget" on COA's website reduced contrast errors but not alternative text errors or errors related to form labels, empty headings, or empty links. COA was required to implement a process for testing to ensure that websites comply with Section 508 specifications for accessibility (i.e., Section 508 of Section 504 of the Rehabilitation Act and World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines).

Various training documents were not consistent with core policies and procedures; therefore, COA was required to revise the training information to clearly state that:

- After a member complains, a COA staff member must document the expression of dissatisfaction as a grievance.
- The staff member who receives the complaint should have a clear procedure to process and document, or refer the grievance.

- The grievance timeline does not stop and start, even if consulting with a provider to obtain additional information. The grievance must be documented, tracked, and written resolution provided, regardless of the required follow-up with the provider or the provider's response.

Two sample grievance resolution letters included language that switched between the terms "grievance," "complaint," and "clinical care grievance." COA was required to update grievance training documents to clarify that any expression of dissatisfaction, other than in response to a notice of adverse benefit determination (NABD), is logged in the system as a grievance and investigated and resolved in accordance with COA's regular grievance procedures. COA was also required to update grievance resolution letters to streamline and/or clarify terms, such as the definition of "grievance" and terms related to the grievance process.

One COA desktop procedure indicated that a grievance would not be processed without a copy of a bill. COA was required to update desktop procedures and training materials related to grievances to ensure that staff members are informed that COA accepts grievances orally as well as in writing.

Although appeal resolution letters for the latter half of calendar year (CY) 2020 were easy to read and showed improvement based on previous corrective action plan (CAP) interventions, the appeal sample included three appeal resolution letters from the first half of CY 2020 with complex clinical language well above the sixth-grade reading level. COA was required to ensure that all appeal resolution letters are written at a reading level that is easy for members to understand.

Similar to findings during the FY 2017–2018 site review report, the provider manual in use during the FY 2020–2021 review contained minimal information regarding the grievance and appeal process. The provider manual and provider grievance form did not include information regarding how COA offers assistance in the grievance or appeal process, and the provider manual did not link to COA's updated grievance and appeal system policy or easily link to the member handbook, which was referenced. COA was required to update the provider manual to include current and complete required details regarding the grievance and appeal systems.

COA: Trended Performance for Compliance With Regulations

Table 3-6 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 3-6—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 (Includes Confidentiality) (2015–2016, 2018–2019)	80%	88%

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard V—Member Information (2017–2018, 2020–2021)	**100%**	**95%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**95%**	**88%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**100%**	**100%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	94%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**NA****	**100%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	100%	89%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

Trended scores over the past two review cycles indicate that COA maintained 100 percent compliance in Standard II—Access and Availability and Standard VII—Provider Participation (Selection) and Program Integrity and maintained a high score in Standard V—Member Information (95 percent), down only 5 percentage points since FY 2017–2018. Standard VI—Grievance and Appeal Systems scores dropped slightly (less than 10 percent) from 95 to 88 percent. Standard IX—Subcontractual Relationships and Delegation was previously unscored as it was not yet applicable to the CHP+ MCOs in FY 2017–2018 and reached 100 percent compliance during the FY 2020–2021 review period, demonstrating that the MCO implemented the revised managed care regulations related to subcontracts and delegation.

Overall, COA reached 100 percent compliance for five of the 10 standards in the most recent review cycles, with one other standard, Standard IV—Member Rights and Protections, increasing since the last review from 80 to 88 percent. Other standards (Standard I—Coverage and Authorization of Services, Standard V—Member Information, Standard VI—Grievance and Appeal Systems, and Standard X—Quality Assessment and Performance Improvement) declined in overall compliance in the most recent review cycle. However, 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 resultant design of compliance monitoring tools—may have impacted comparability of the compliance results over review cycles. While COA demonstrated consistent performance or improvement across review cycles in six of the 10 standards, HSAG recommends that COA evaluate its systems and processes for opportunities to improve compliance with the four standards in which scores declined in the most recent review cycle, especially those remaining under 90 percent compliance: Standard I—Coverage and Authorization of Services, Standard IV—Member Rights and Protections, Standard X—Quality Assessment and Performance Improvement.

Validation of Network Adequacy

COA: Strengths

COA participated in all quarterly network adequacy reporting. While COA did not meet all minimum time and distance network requirements across all counties in each county designation, COA's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, COA should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

Findings

Table 3-7 shows the results achieved by COA for FY 2018–2019 through FY 2020–2021.

Table 3-7—Top-Box Scores for COA

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Statewide Aggregate Rate
Getting Needed Care	87.7%	83.8%	78.9%	80.1%
Getting Care Quickly	90.5%	91.1%	85.7%	86.6%
How Well Doctors Communicate	94.8%	97.7%	93.0% ▼ ↓	94.1%
Customer Service	81.9%	79.9%+	87.4%+	87.2%
Rating of Health Plan	69.3%	62.4%	66.4%	67.0%
Rating of All Health Care	67.7%	69.5%	72.8%	72.7%
Rating of Personal Doctor	78.0%	78.2%	78.1%	77.4%
Rating of Specialist Seen Most Often	77.1%+	73.8%+	67.1%+	69.6%

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 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*
Statewide aggregate rate scores are added for reference.
↑ *Indicates the health plan's score is statistically significantly higher than the statewide aggregate rate score.*
↓ *Indicates the health plan's score is statistically significantly lower than the statewide aggregate rate score.*

COA: Strengths

For the CHP+ population, COA showed an upward score trend over the three-year period on one measure, *Rating of All Health Care*. In addition, COA scored higher than the statewide aggregate rate in FY 2020–2021 for three measures: *Customer Service*, *Rating of All Health Care*, and *Rating of Personal Doctor*, although none were statistically significantly higher.

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

For the CHP+ population, COA scored lower than the statewide aggregate rate in FY 2020–2021 for five measures related to the access, timeliness, and quality of care domains: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Health Plan*, and *Rating of Specialist Seen Most Often*. COA scored statistically significantly lower in FY 2020–2021 than in FY 2019–2020

and the statewide aggregate rate on one measure related to the quality of care domain, *How Well Doctors Communicate*. In addition, measures related to the access to and quality of care domains, *Getting Needed Care* and *Rating of Specialist Seen Most Often*, showed a downward score trend from FY 2018–2019 through FY 2020–2021. Performance for the *Getting Needed Care* measure is designed to measure whether parents/caretakers felt they were able to get care and appointments as soon as their child needed but may also be related to other factors. Performance for the *Getting Care Quickly* measure assesses whether parents/caretakers felt their child received the services and appointments they needed in a timely manner; however, it may also be related to a variety of other factors. Performance for the *How Well Doctors Communicate* measure may be related to a variety of factors including whether parents/caretakers felt their child's personal doctor explained things in an understandable way, listened carefully, showed respect, and spent enough time with them. Performance for the *Rating of Health Plan* measure may be related to a variety of factors including whether parents/caretakers felt they received quality, timely, and accessible services overall. Performance for the *Rating of Specialist Seen Most Often* measure may be related to a variety of factors including whether parents/caretakers felt they received quality and timely services from specialists to whom their child talked. HSAG recommends that the Department work with COA and explore what may be driving a decrease in the scores for these measures from FY 2018–2019 to FY 2020–2021 and develop initiatives for improvement, where appropriate.

Denver Health Medical Plan, Inc.

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-8 and Table 3-9 display the FY 2020–2021 validation findings for DHMP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, DHMP completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, DHMP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statements. The SMART aim statements that DHMP defined for the two PIP outcome measures in Module 1 are provided in Table 3-8.

Table 3-8—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH, from 68.46% to 76.15%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH from 46.43% to 75.00%.

In Module 2—Intervention Determination, DHMP conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, DHMP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by DHMP in Module 2 are summarized for the two PIP outcome measures Table 3-9. The PIP had not progressed to the point of deploying and testing interventions. The interventions that DHMP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-9—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, DHMP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. DHMP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

DHMP: Strengths

The validation findings suggest that DHMP was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. DHMP also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for

members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

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

As DHMP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- DHMP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as DHMP progresses through determining and testing interventions.
- DHMP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, DHMP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to DHMP's HEDIS MY 2020 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 3-10 shows the performance measure results for DHMP for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-10—Performance Measure Results for DHMP

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	67.46%	82.26%	81.94%	75th–89th
Combination 3	65.87%	82.26%	81.94%	≥90th
Combination 4	65.87%	82.26%	81.94%	≥90th
Combination 5	57.94%	79.03%	75.00%	≥90th
Combination 6	46.03%	59.68%	66.67%	≥90th
Combination 7	57.94%	79.03%	75.00%	≥90th
Combination 8	46.03%	59.68%	66.67%	≥90th
Combination 9	41.27%	58.06%	63.89%	≥90th
Combination 10	41.27%	58.06%	63.89%	≥90th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	82.24%	86.71%	88.00%	75th–89th
Combination 2 (Meningococcal, Tdap, HPV)	55.92%	53.80%	54.00%	≥90th
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	64.52%	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	66.18%	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	46.11%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	21.80%	23.81%	63.96%^	10th–24th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Counseling for Nutrition—Total	7.93%	8.31%	70.36%^	25th–49th
Counseling for Physical Activity—Total	6.65%	7.41%	69.92%^	50th–74th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	47.22%	47.89%	44.29%	10th–24th
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[1]				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	NA	NA	—
Cholesterol Testing—Total	—	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[1]				
Ages 3 to 17 Years	—	90.58%	85.07%	50th–74th
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	—	97.88%	98.49%	≥90th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	21.49	22.57	13.67	≥90th
Outpatient Visits—Total	135.56	158.85	127.95	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	0.82	1.05	0.69	<10th
Total Average Length of Stay (Total Inpatient)	3.07	2.59	2.30	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Medicine)	0.60	0.79	0.50	<10th
Total Average Length of Stay (Medicine)	2.59	2.30	2.00†	<10th
Total Discharges per 1,000 Member Months (Surgery)	0.17	0.17	0.13	<10th
Total Average Length of Stay (Surgery)	5.07†	3.90†	3.57†	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.09	0.16	0.10	<10th
Total Average Length of Stay (Maternity)	2.00†	2.60†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.14	0.18	0.12	≥90th
Average Days Supplied per Antibiotic Script—Total	11.28	10.88	12.43	<10th
Average Scripts PMPY for Antibiotics of Concern	0.03	0.04	0.03	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	24.04%	23.74%	25.52%	≥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 HEDIS MY 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 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 MY 2018 or HEDIS MY 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.

DHMP: Strengths

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

- *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*
- *Childhood Immunization Status—Combinations 2 through 10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

For HEDIS MY 2020, DHMP demonstrated strong performance with vaccinating children and adolescents by ranking above the 75th percentile for all 11 measure indicator rates and above the 90th percentile for nine of 11 (81.8 percent) measure indicator rates. DHMP's rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator demonstrated a statistically significant improvement in performance 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 MY 2020 measure rates were determined to be low-performing rates for DHMP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS MY 2019):

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

Despite demonstrating significant improvement for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator rate, DHMP continued to demonstrate opportunities to improve as the measure rate fell below the 25th percentile. The MCO should continue to work with the school-based health centers (SBHCs) to develop initiatives to improve this measure within the community service sites. The improvement in the rate improved significantly, and a continued focus on the collaboration between DHMP and SBHCs will help create proper guidance for children as it relates to physical activity and nutrition.

Assessment of Compliance With CHIP Managed Care Regulations

DHMP Overall Evaluation

Table 3-11 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 2020–2021.

Table 3-11—Summary of DHMP Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	21	20	19	1	0	1	95%
Standard VI—Grievance and Appeal Systems	34	34	32	2	0	0	94%
Standard VII—Provider Participation (Selection) and Program Integrity	16	15	14	1	0	1	93%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**73**	**68**	**5**	**0**	**2**	**93%***

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

Table 3-12 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 2020–2021.

Table 3-12—Summary of DHMP Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	36	36	28	8	0	78%
Appeals	60	53	53	0	7	100%
Totals	**96**	**89**	**81**	**8**	**7**	**91%***

**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 maintained an efficient system to ensure new CHP+ members receive a CHP+ identification card, a welcome letter, a medical home letter, and other resource materials, including how to obtain translation services. DHMP's website was easy to navigate and included an accessibility option tab that allowed the user to change font size, line spacing, contrast, and enhance inputs such as links, buttons, and menus. The member handbook included the necessary information regarding member rights and responsibilities, recognizing and reporting fraud, filing grievances and appeals, cost-sharing, and emergency access. Informational materials used easy-to-understand language.

Policies and procedures used to address both grievances and appeals were comprehensively written and specified who was able to file a grievance, appeal, and a State fair hearing (SFH) on behalf of a member. The policies, letters, and handbooks for members and providers included correct time frames for filing grievances, appeals, and SFHs. DHMP resolved all grievances and appeals in a timely manner and all appeal resolution letters reviewed were easy to understand and included the required content.

The network management team described reports that assessed both qualitative and quantitative data related to network adequacy, such as provider referral barriers, grievance and appeal trends, and other indicators of network gaps. Provider education and training were conducted by the network management team through various means such as newsletters, direct interactions, letters, and postings to the centralized provider Web portal. Efforts to retain providers included an annual Provider and Practitioner Experience Survey, which assessed satisfaction.

The Enterprise Compliance Services (ECS) program description presented well-developed arrangements and procedures that articulated DHMP's commitment to comply with federal, State, and contract requirements related to detecting and preventing fraud, waste, and abuse. The program description included clear responsibilities of the chief executive officer, board of directors, compliance committee, and chief compliance and audit officer. General staff members were required to complete compliance training at onboarding and annually thereafter, and staff members reported that in-person, individualized trainings were conducted for board members. Compliance training requirements were noted in policy and described by staff members as ranging in expectations from maintenance of medical licenses, certifications in healthcare compliance, research compliance, internal audit, and more.

DHMP's policies described predelegation evaluation procedures, initial delegation activities, and a process for managing delegated credentialing activities. Many of the delegates performed credentialing and recredentialing, followed by delegated printing and mailing of member materials, pharmacy services, and hospital/clinic services. Oversight included regular meetings, a corrective action process, and a tracking log. DHMP supplied a sample of audit results for review.

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

The member handbook section regarding continued benefits during an appeal and SFH was combined in a way that the criteria were not entirely accurate or clear. Procedures, timelines, and criteria within the section switched back and forth between appeal and SFH, which could be confusing to the member. DHMP was required to update the Continuation of Benefits section of the member handbook to clarify which procedures and timelines apply to appeals and which apply to SFHs.

DHMP processed grievances according to the federal requirements only when the grievances met DHMP's definition of a "formal" grievance. Expressions of dissatisfaction that were able to be resolved at the point of contact were handled through a less formal complaint process that did not fully meet the requirements. Additionally, within the record review sample, HSAG discovered that one potential denial of service was misclassified and processed as a grievance. DHMP was required to develop and implement a mechanism to define, identify, and manage grievances in compliance with all grievance requirements, and ensure this process is used consistently to address any expression of dissatisfaction received from a member about any matter other than an adverse benefit determination. DHMP was required to provide training to staff members to clearly define the difference between a grievance and an appeal to ensure accurate documentation and corresponding procedures.

Sample grievance resolution letters included an attachment stating that the member could file an appeal, a quick appeal, or an SFH following the resolution of the grievance. This attachment was misleading to the member as there is no appeal or SFH process available to members as a result of the grievance resolution. The appeal and SFH processes are only available to members in response to an adverse benefit determination. DHMP was required to remove the appeal and SFH attachment from grievance resolution letters.

Although DHMP's desktop policy included procedural steps to verify that services billed had been received by the member, per staff member report, the verification process had not occurred for the CHP+ line of business in CY 2020 and had not launched by the time of the FY 2020–2021 compliance review. DHMP was required to ensure that CHP+ services are verified regularly to ensure services represented by providers were received by members.

Language used in the subcontracts reviewed varied significantly across contracts. While the required language was included in the new contract template, three of the four subcontracts reviewed did not contain all required language. DHMP was required to revise various subcontracts to include all required language (i.e., CMS, the Department of Health and Human Services Office of Inspector General [HHS-OIG], Comptroller General, or other designees have the right to audit, the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available).

DHMP: Trended Performance for Compliance With Regulations

Table 3-13 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 3-13—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 (Includes Confidentiality) (2015–2016, 2018–2019)	100%	100%
Standard V—Member Information (2017–2018, 2020–2021)	**83%**	**95%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**91%**	**94%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**79%**	**93%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	98%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**NA****	**75%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	93%	89%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

Trending scores over the past two review cycles indicate that DHMP improved its performance in five of the 10 standards; maintained compliance scores at 100 percent compliance in one standard, Standard IV—Member Rights and Protections; and experienced a decrease in compliance scores in three standards.

Two of the four standards reviewed in FY 2020–2021 showed substantial improvement (10 or more percentage points): Standard V—Member Information and Standard VII—Provider Participation (Selection) and Program Integrity. Standard VI—Grievance and Appeal Systems showed slight improvement (10 percentage points or less) increasing from 91 to 94 percent compliance. And the fourth standard, Standard IX—Subcontractual Relationships and Delegation, had not previously been reviewed due to the revisions released in the 2016 managed care regulations not being applicable for CHP+ MCOs until FY 2018–2019.

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 resultant design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods. HSAG recommends that DHMP review policies and procedures and focus efforts to improve compliance with standards currently under 90 percent compliance, particularly the three that decreased during the most recent review cycle: Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard X—Quality Assessment and Performance Improvement.

Validation of Network Adequacy

DHMP: Strengths

DHMP participated in all quarterly network adequacy reporting. While DHMP did not meet all minimum time and distance network requirements across all counties in each county designation, DHMP's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, DHMP should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

Findings

Table 3-14 shows the results achieved by DHMP for FY 2018–2019 through FY 2020–2021.

Table 3-14—Top-Box Scores for DHMP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Statewide Aggregate Rate
Getting Needed Care	79.7%	80.5%	83.4%	80.1%
Getting Care Quickly	85.0%	85.9%	86.2%	86.6%
How Well Doctors Communicate	94.4%	96.9%	94.9%	94.1%
Customer Service	87.8%	86.1%+	87.0%	87.2%
Rating of Health Plan	65.4%	65.0%	70.9%	67.0%
Rating of All Health Care	69.2%	66.5%	76.5% ▲ ↑	72.7%
Rating of Personal Doctor	75.7%	85.1%	82.8% ↑	77.4%
Rating of Specialist Seen Most Often	85.3%+	77.1%+	71.2%+	69.6%

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 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*
Statewide aggregate rate scores are added for reference.
↑ *Indicates the health plan's score is statistically significantly higher than the statewide aggregate rate score.*
↓ *Indicates the health plan's score is statistically significantly lower than the statewide aggregate rate score.*

DHMP: Strengths

For the CHP+ population, DHMP scored statistically significantly higher in FY 2020–2021 than in FY 2019–2020 on one measure, *Rating of All Health Care*. In addition, DHMP showed an upward score trend over the three-year period on the following two measures: *Getting Needed Care* and *Getting Care Quickly*. In addition, DHMP scored higher than the statewide aggregate rate in FY 2020–2021 for six measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. DHMP scored statistically significantly higher than the statewide aggregate rate for *Rating of All Health Care* and *Rating of Personal Doctor*.

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

One measure related to the quality of care domain, *Rating of Specialist Seen Most Often*, showed a downward score trend from FY 2018–2019 through FY 2020–2021. Also, DHMP scored lower than the statewide aggregate rate in FY 2020–2021 for two measures: *Getting Care Quickly* and *Customer Service*, although neither was statistically significantly lower. Performance for the *Getting Care Quickly* measure may be related to a variety of factors including whether parents/caretakers felt their child received the services and appointments they needed in a timely manner. Performance for the *Customer Service* measure may be related to a variety of factors including whether parents/caretakers felt they received the information or help they needed and were treated with courtesy and respect by the staff. Performance for the *Rating of Specialist Seen Most Often* measure may be related to a variety of factors including whether parents/caretakers felt they received quality and timely services from specialists to whom their child talked. HSAG recommends that DHMP explore what may be driving a decrease in the score for this measure from FY 2018–2019 through FY 2020–2021 and develop initiatives for improvement, where appropriate.

Friday Health Plans of Colorado

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-15 and Table 3-16 display the FY 2020–2021 validation findings for FHP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, FHP completed Module 1—PIP Initiation and initiated Module 2—Intervention Determination. In Module 1, FHP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statements. The SMART aim statements that FHP defined for the two PIP outcome measures in Module 1 are provided in Table 3-15.

Table 3-15—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to increase the percentage of CHP+ members ages 12–17 years of age to have the correct coding by the provider when receiving a depression screening during their outpatient visit from 2% to 16%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to maintain the percentage of CHP+ members ages 12–17 years of age who receive a follow-up visit within 30 days of the positive depression screening at 90% or higher.

In Module 2—Intervention Determination, FHP conducted process mapping and FMEA to identify potential interventions to test for the PIP. In Module 2, FHP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by FHP in the initial Module 2 submission are summarized for the two PIP outcome measures in Table 3-16. The PIP had not progressed to the point of deploying and testing interventions. The interventions that FHP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-16—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP*

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider requirements for depression screening defined by quality metrics.
Potential Interventions	• Provider education on proper coding for depression screening.

Measure 1—*Depression Screening*	
	• Provider education on the importance of screening members 12 to 17 years of age for depression and parent/caregiver engagement in the depression screening process.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Support for provider reporting of depression screening.
Potential Interventions	• Provider education on correct depression screening codes and the importance of correct coding and reporting.

**Note: FHP did not pass Module 2 during FY 2020–2021. The key drivers and potential interventions listed in the table are preliminary, based on the initial Module 2 submission.*

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, FHP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. FHP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

FHP: Strengths

The validation findings suggest that FHP was successful in building a QI team and defining specific and measurable goals for the project. The health plan also began using QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression.

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

As FHP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year, identifying and selecting interventions to test through PDSA cycles, HSAG recommends the following:

- FHP should ensure adequate staffing and resources are available to support intervention testing and other PIP activities. The health plan should include in the PIP team staff with QI skills and experience to support methodologically sound PDSA cycles and analyses of process and outcome data.
- FHP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver

diagram should be updated regularly to incorporate knowledge gained and lessons learned as FHP progresses through determining and testing interventions.

- FHP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, FHP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to FHP's HEDIS MY 2020 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 3-17 shows the performance measure results for FHP for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-17—Performance Measure Results for FHP

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	4.76%	0.00%	NA	—
Combination 3	4.76%	0.00%	NA	—
Combination 4	4.76%	0.00%	NA	—
Combination 5	4.76%	0.00%	NA	—
Combination 6	0.00%	0.00%	NA	—
Combination 7	4.76%	0.00%	NA	—
Combination 8	0.00%	0.00%	NA	—
Combination 9	0.00%	0.00%	NA	—
Combination 10	0.00%	0.00%	NA	—
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	26.32%	41.94%	43.40%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	12.28%	8.06%	22.64%^	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	NA	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	NA	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	32.50%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	9.70%	13.69%	**6.18%^^**	<10th
Counseling for Nutrition—Total	4.65%	5.38%	2.56%	<10th
Counseling for Physical Activity—Total	6.26%	1.96%	3.62%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	NA	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[1]				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	NA	NA	—
Cholesterol Testing—Total	—	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[1]				
Ages 3 to 17 Years	—	65.81%	77.66%	25th–49th
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	—	91.67%	93.96%	50th–74th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	NA	NA	—

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	17.33	20.17	12.71	≥90th
Outpatient Visits—Total	166.81	190.96	141.10	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	0.37	0.32	0.50	<10th
Total Average Length of Stay (Total Inpatient)	2.33†	1.71†	2.33†	<10th
Total Discharges per 1,000 Member Months (Medicine)	0.21	0.23	0.17	<10th
Total Average Length of Stay (Medicine)	2.00†	1.60†	1.33†	<10th
Total Discharges per 1,000 Member Months (Surgery)	0.17	0.09	0.28	<10th
Total Average Length of Stay (Surgery)	1.50†	2.00†	2.80†	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.00	0.00	0.11	<10th
Total Average Length of Stay (Maternity)	NA	NA	3.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	12.00	0.42	0.27	≥90th
Average Days Supplied per Antibiotic Script—Total	99.95	102.83	9.65	25th–49th
Average Scripts PMPY for Antibiotics of Concern	2.32	0.15	0.10	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	19.35%	35.97%	38.94%	50th–74th

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

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS MY 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 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 MY 2018 or HEDIS MY 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.

FHP: Strengths

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

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

For HEDIS MY 2020, FHP demonstrated strong performance in ensuring young women were not unnecessarily screened for cervical cancer, with the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure rate exceeding the 90th percentile.

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

The following HEDIS MY 2020 measure rates were determined to be low-performing rates 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 MY 2019):

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *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*

FHP's performance demonstrated opportunities to improve the rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure with rates falling below the 10th percentile. The MCO should work to identify barriers for children gaining access to nutrition counseling and physical activity (e.g., determine whether the COVID-19 pandemic created a barrier, or whether children did not have access to physical activity in school). With better information about barriers to care, FHP can design more appropriate interventions to improve access to care measures.

Assessment of Compliance With CHIP Managed Care Regulations

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 2020–2021.

Table 3-18—Summary of FHP Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	21	21	14	6	1	0	67%
Standard VI—Grievance and Appeal Systems	34	34	18	16	0	0	53%
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	12	4	0	0	75%
Standard IX—Subcontractual Relationships and Delegation	4	4	2	2	0	0	50%
Totals	**75**	**75**	**46**	**28**	**1**	**0**	**61%***

**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 2020–2021.

Table 3-19—Summary of FHP Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	NA	NA	NA	NA	NA	NA*
Appeals	42	42	14	28	0	33%
Totals	**42**	**42**	**14**	**28**	**0**	**33%****

**FHP reported that it had received no grievances during the review period.*

***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 provided member informational materials through its website and the welcome kit (mailed to members) informed members that the information is available in written form upon request within five business days. The welcome kit included a benefit table that provided an overview of the majority of benefit categories and associated copays.

Policies and procedures accurately described a member's right to file a grievance verbally or in writing at any time and the right to appoint an authorized representative. Staff members were able to explain their efforts to inform members of their right to submit documentation to support an appeal, and appeals coordinators described their efforts to pursue appeals when submitted orally. Although no grievances were reported for CY 2020, FHP documentation accurately described the timelines for sending grievance acknowledgement, resolution, and extension letters when applicable. Clinical staff members with appropriate expertise who were not previously involved in cases were available to make decisions on grievances and appeals, and customer service staff members were available to assist with grievances and appeals in English and Spanish. Customer service training manuals outlined a member-centered and empathetic approach to dealing with complaints, emphasizing listening skills and empowering the customer service representative to take additional steps to help resolve the member's issue.

FHP's network access management plan described efforts to recruit and retain providers within its service area. Staff members described a "broad-based yet personalized" approach to developing the provider network to support the rural area served. Staff members reported that 25 percent of the provider directory was monitored each quarter to verify data accuracy.

The compliance committee reportedly met quarterly. Training for staff members occurred for new hires and annually, with additional communications sent through email for ad hoc updates. Policies outlined provisions for prompt reporting of overpayments. Staff members described multiple methods for reviewing for overpayment, including general claims reconciliation; monitoring high dollar claims, such as inpatient services; and QI projects involving MRRs, which targeted accurate documentation.

FHP staff members reported various delegates were used for pharmacy and vision services and supplying printed materials. FHP submitted evidence of having a written agreement with each delegation subcontractor. All sample agreements reviewed included the subcontractor's agreement to perform the duties under the contract, provisions for remedies for instances of subcontractor nonperformance of the subcontracted activities, and agreement to comply with all regulations and laws pertaining to work under the contract.

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

Critical member information such as the member handbook and welcome kit were written at a reading level much higher than sixth grade. FHP was required to develop a mechanism to use tools or mechanisms of FHP's choice to ensure that member informational materials are easily understood.

FHP's CHP+ member handbook contained a few definitions that were inconsistent with definitions outlined in the State contract. FHP was required to review definitions and terms for consistency with contract language.

The member handbook contained some information in a font smaller than 12-point or equivalent font sizes. There was no large print tagline, and the partial tagline did not include information about how to request auxiliary aids other than through Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD), written translation, or oral interpretation in any language. FHP was required to ensure that member informational materials are written in, at a minimum, 12-point font (or equivalent) and contain taglines written in a large or conspicuously visible font size and include how members may request auxiliary aids and services in addition to TTY/TDD, written translation, and oral interpretation.

FHP's website did not prominently display critical information such as the provider directory, member handbook, and formulary, and the overall website was difficult to navigate and contained numerous content and contrast errors. FHP was required to ensure that information available for members electronically is placed in a website location that is prominent and that the information is readily accessible in compliance with Section 508 guidelines.

Neither FHP's Portable Document Format (PDF) version of the provider directory, nor the provider search feature on FHP's website included information about whether the providers have completed cultural competency training or whether the providers' offices have accommodations for members with physical disabilities. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, FHP was not required to complete a corrective action related to completed cultural competency training. However, FHP was required to ensure that its provider directory includes information about whether the providers' offices have accommodations for members with physical disabilities.

The member handbook included incorrect time frames and requirements related to the continuation of services during an appeal and SFH. Examples provided for when to file an appeal were not entirely clear and could be interpreted inaccurately. However, due to revisions to the Medicaid and CHIP managed care regulations, FHP was not required to update the continuation of services information but was required to remove references regarding continuation of services. FHP was required to revise the member handbook information about the grievances and appeals to ensure that members understand their right to file an appeal continues 60 days following the adverse benefit determination whether or not the member is requesting continuation of services during the appeal. FHP was also required to clarify in its examples of appealable situations that appeals may only be filed in response to NABDs.

HSAG found that FHP had many opportunities for improvement related to grievance and appeal systems. FHP was required to:

- Update and expand its grievance and appeal policies, procedures, and letter templates to more clearly define both "grievance" and "appeal" and delineate processes. Additionally, FHP was required to develop detailed procedures to better train and monitor staff members to ensure that grievances and appeals are being collected, processed, and resolved in compliance with federal and State requirements.
- Update and expand its internal appeal documentation to more clearly define appeals; develop detailed procedures to better train and monitor staff members and ensure that appeals are being collected, processed, and resolved in compliance with federal and State requirements; and revise the member handbook to clarify that members may appeal the denial of services once an NABD has been received.
- Clarify "complaints" are the same as "grievances" and must be treated the same way. FHP was required to remove references that there are differences in requirements to process and document formal and informal grievances or complaints.
- Inform members that auxiliary aids and interpreter services are available at no cost to the member in order to help members with completing any forms or other procedural steps related to grievances and appeals.
- Update desktop procedures to clarify that for the CHP+ line of business there is only one level of appeal for CHP+ members.
- Develop a mechanism to ensure that member acknowledgement letters for each appeal are sent in a timely manner.
- Inform the member of their right to file a grievance in response to a denial of an expedited appeal request.
- Update documents to reflect the 10-working-day timeline and develop a mechanism to ensure appeals are resolved and members are notified within timeliness standards.
- Remove references to three business days and update all time frames to reflect that both verbal and written notice must take place within the 72-hour time frame.
- Revise documents to include the member's right to file a grievance in response to an extension if the member disagrees with the extension.
- Update the SFH timelines to reflect that the member has 120 days from the appeal resolution to request an SFH. FHP was also required to remove the reference to the original effective date of the termination of the services from the SFH section of its documents.
- Enhance policies, procedures, and monitoring practices to ensure that all required grievance information is maintained.
- Ensure updates and accurate details listed above are updated within the provider manual.

The Compliance Program description lacked details regarding the specific training for the compliance officer and health plan managers. Staff interviews confirmed that no specific training plans were in place for compliance leadership beyond the general internal staff-level training. FHP was required to further develop training and education requirements for the compliance officer and compliance management staff members.

The False Claims Act was accurately described within the Compliance Program description; however, it did not include specific details regarding staff members' rights to be protected. Furthermore, the description did not consistently outline details about how staff members should make a prompt referral (i.e., reporting timelines, appropriate method for reporting). The training manual submitted did not contain additional information regarding compliance, fraud, waste, abuse, or reporting hotlines. While FHP did describe that suspension of payments would be processed through the physician advisory committee (PAC), FHP did not submit written procedures regarding provisions for suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. FHP was required to update its Compliance Program description and supporting documents to further detail staff members' right to be protected under the False Claims Act and include additional details (i.e., reporting methods, contact methods, timelines, etc.) for prompt referral of fraud, waste, and abuse both internally and also to the State as applicable.

FHP did not submit and could not describe specific procedures to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. Methodology discussed by staff members included financial and claims review and general reconciliation processes but did not include a proactive way of validating services with members directly. FHP was required to develop a method, such as member sampling, to assess regularly whether billed member services have been furnished by a provider.

FHP did not submit evidence of internal procedures for providing written disclosures of ownership and control or prohibited affiliations. FHP was required to create and implement procedures to outline how FHP provides disclosures of ownership and control as well as prohibited affiliations to the State.

Only one sample delegation agreement specified reporting responsibilities. FHP was required to amend the remaining contracts to ensure that the delegation agreements specify the delegate's activities or obligations and related reporting responsibilities.

Two other delegation agreements did not include the required provisions that the State, CMS, HHS-OIG, Comptroller General, or other designees have the right to audit, evaluate, and inspect books, records, or premises as deemed necessary by the applicable agency. The contracts also required retention of records for only six years instead of the required 10 years following the final date of the contract or agreement. None of the agreements reviewed included specific provisions related to CMS' right to audit based on suspicion of fraud. FHP was required to amend all delegation agreements to ensure inclusion of the required contract provisions related to State, CMS, HHS-OIG, Comptroller General, or other designee rights to audit, as well all required provisions and timelines.

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 (Includes Confidentiality) (2015–2016, 2018–2019)	80%	88%
Standard V—Member Information (2017–2018, 2020–2021)	**92%**	**67%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**82%**	**53%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**93%**	**75%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	77%	86%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**NA****	**50%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	73%	83%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

Trending scores over the past two review cycles indicate improved performance in five of the 10 standards, decreased compliance within four standards, and one standard being reviewed for the first time in the FY 2020–2021 cycle. Three of the four standards reviewed in FY 2020–2021 showed decreased compliance since the previous review cycle. Standard IX—Subcontractual Relationships and Delegation, which was reviewed for the first time since Medicaid and CHIP regulation revision, demonstrated 50 percent compliance (two out of four requirements being compliant).

In previous review cycles, FHP reached above 90 percent compliance for Standard I—Coverage and Authorization of Services, Standard V—Member Information, and Standard VII—Provider Participation (Selection) and Program Integrity; however each of these standards dropped below 90 percent compliance in the most recent review period, scoring 63 percent, 67 percent, and 75 percent respectively.

HSAG recommends that FHP review policies, procedures, reporting, and trainings against both federal and State requirements and continue to develop systems to monitor its organization. Notably, the four lowest scoring standards should take priority: Standard IX—Subcontractual Relationships and Delegation, Standard VI—Grievance and Appeal Systems, Standard I—Coverage and Authorization of Services, and Standard V—Member Information.

Validation of Network Adequacy

FHP: Strengths

FHP participated in all quarterly network adequacy reporting. While FHP did not meet all minimum time and distance network requirements across all counties in each county designation, FHP's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, FHP should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

Findings

Table 3-21 shows the results achieved by FHP for FY 2018–2019 through FY 2020–2021.

Table 3-21—Top-Box Scores for FHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Statewide Aggregate Rate
Getting Needed Care	90.1%+	81.9%+	83.2%+	80.1%
Getting Care Quickly	91.0%+	94.1%+	87.8%+	86.6%
How Well Doctors Communicate	92.9%	99.0%+	98.7%+ ↑	94.1%
Customer Service	84.0%+	97.5%+	88.4%+	87.2%
Rating of Health Plan	55.2%	59.1%	63.8%	67.0%
Rating of All Health Care	50.6%	59.8%+	58.6%+ ↓	72.7%
Rating of Personal Doctor	71.0%	74.5%	63.9% ↓	77.4%
Rating of Specialist Seen Most Often	71.1%+	77.8%+	70.0%+	69.6%

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 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*
Statewide aggregate rate scores are added for reference.
↑ *Indicates the health plan's score is statistically significantly higher than the statewide aggregate rate score.*
↓ *Indicates the health plan's score is statistically significantly lower than the statewide aggregate rate score.*

FHP: Strengths

For the CHP+ population, FHP showed an upward score trend over the three-year period on one measure, *Rating of Health Plan*. In addition, FHP scored higher than the statewide aggregate rate in FY 2020–2021 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*. FHP scored statistically significantly higher than the statewide aggregate rate for *How Well Doctors Communicate*.

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

FHP experienced no statistically significant decreases in FY 2020–2021 scores when compared to FY 2019–2020, nor a downward score trend from FY 2018–2019 through FY 2020–2021 on any measure. However, FHP scored lower than the statewide aggregate rate in FY 2020–2021 for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. FHP scored

statistically significantly lower than the statewide aggregate rate for *Rating of All Health Care* and *Rating of Personal Doctor*. Performance for the *Rating of Health Plan* measure may be related to a variety of factors including whether parents/caretakers felt they received quality, timely, and accessible services overall. Performance for the *Rating of All Health Care* measure may be related to a variety of factors including whether parents/caretakers felt they received the care, tests, or treatment as soon as their child needed. Performance for the *Rating of Personal Doctor* measure may be related to a variety of factors including whether parents/caretakers felt their child's doctor explained things in an understandable way, listened carefully, showed respect, spent enough time with their child, discussed how their child is feeling, and seemed up to date about the care their child received from other doctors. HSAG recommends that the Department work with FHP and explore what may be driving lower scores for these measures and develop initiatives for improvement, where appropriate.

Kaiser Permanente Colorado

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-22 and Table 3-23 display the FY 2020–2021 validation findings for Kaiser's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, Kaiser completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, Kaiser defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statements. The SMART aim statements that Kaiser defined for the two PIP outcome measures in Module 1 are provided in Table 3-22.

Table 3-22—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who are screened for depression annually from 9.93% to 20%. This will be achieved by utilizing key driver diagram interventions.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12-17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.

In Module 2—Intervention Determination, Kaiser conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, Kaiser updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by Kaiser in Module 2 are summarized for the two PIP outcome measures in Table 3-23. The PIP had not progressed to the point of deploying and testing interventions. The interventions that Kaiser ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-23—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Ensure appropriate depression screening questionnaire is administered and recorded in the EHR. • Increase annual well visits among 12- to 17-year-olds.

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

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, Kaiser will continue testing interventions for the Depression Screening and Follow-Up After a Positive Depression Screen PIP through the end of FY 2021–2022. Kaiser will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

Kaiser: Strengths

The validation findings suggest that Kaiser was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. Kaiser also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

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

As Kaiser continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- Kaiser should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as Kaiser progresses through determining and testing interventions.
- Kaiser should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, Kaiser should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to Kaiser's HEDIS MY 2020 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 3-24 shows the performance measure results for Kaiser for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-24—Performance Measure Results for Kaiser

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	69.46%	75.94%	68.13%	10th–24th
Combination 3	67.36%	74.33%	67.50%	25th–49th
Combination 4	66.95%	74.33%	67.50%	25th–49th
Combination 5	62.76%	69.52%	63.75%	50th–74th
Combination 6	41.84%	59.89%	52.50%	75th–89th
Combination 7	62.34%	69.52%	63.75%	50th–74th
Combination 8	41.84%	59.89%	52.50%	75th–89th
Combination 9	40.59%	56.15%	49.38%	75th–89th
Combination 10	40.59%	56.15%	49.38%	75th–89th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	82.84%	82.33%	85.81%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	56.44%	53.67%	59.46%	≥90th
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	51.35%	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	61.18%	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	34.60%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	98.57%	98.04%	**93.52%^^**	≥90th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Counseling for Nutrition—Total	96.18%	95.14%	**89.31%^^**	≥90th
Counseling for Physical Activity—Total	96.18%	95.14%	**89.31%^^**	≥90th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	45.51%	52.69%	45.83%	10th–24th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.25%	0.00%	≥90th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication[1]				
Initiation Phase	45.16%	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	NA	NA	—
Cholesterol Testing—Total	—	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[1]				
Ages 3 to 17 Years	—	92.39%	89.70%	75th–89th
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	—	97.51%	97.75%	≥90th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	93.33%	97.06%	≥90th
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	18.86	21.93	14.61	≥90th
Outpatient Visits—Total	133.57	158.31	108.70	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	0.49	0.69	0.49	<10th
Total Average Length of Stay (Total Inpatient)	3.67	4.86	3.22	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Medicine)	0.40	0.46	0.34	<10th
Total Average Length of Stay (Medicine)	2.29	3.35	3.45	10th–24th
Total Discharges per 1,000 Member Months (Surgery)	0.08	0.22	0.14	<10th
Total Average Length of Stay (Surgery)	10.50†	8.17†	2.77†	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.01	0.02	0.02	<10th
Total Average Length of Stay (Maternity)	3.00†	3.00†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.19	0.29	0.17	≥90th
Average Days Supplied per Antibiotic Script—Total	12.47	11.52	14.16	<10th
Average Scripts PMPY for Antibiotics of Concern	0.05	0.08	0.04	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	24.21%	27.59%	25.00%	≥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 HEDIS MY 2020 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 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 MY 2018 or HEDIS MY 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.

Kaiser: Strengths

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

- *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years*
- *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*
- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*

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

For HEDIS MY 2020, Kaiser demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for eight of 11 (72.7 percent) measure indicator rates. Additionally, the MCO demonstrated appropriate management of members with respiratory conditions 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 MY 2020 measure rates were determined to be low-performing rates for Kaiser (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from HEDIS MY 2019):

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Childhood Immunization Status—Combination 2*

Kaiser demonstrated opportunities to improve in the Preventive Screening domain with the *Chlamydia Screening in Women—Ages 16 to 20 Years* measure indicator falling below the 25th percentile. The MCO should identify factors contributing to low rates for this measure and ensure that women are receiving proper screenings.

Assessment of Compliance With CHIP Managed Care Regulations

Kaiser Overall Evaluation

Table 3-25 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2020–2021.

Table 3-25—Summary of Kaiser Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	21	21	19	2	0	0	90%
Standard VI—Grievance and Appeal Systems	34	33	23	10	0	1	70%
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	16	0	0	0	100%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**74**	**61**	**13**	**0**	**1**	**81%***

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

Table 3-26 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2020–2021.

Table 3-26—Summary of Kaiser Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	54	53	1	6	98%
Appeals	54	47	45	2	6	96%
Totals	**114**	**101**	**98**	**3**	**12**	**97%***

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

Kaiser: Strengths

Kaiser conducted outreach to CHP+ members at enrollment and annually by mailing a postcard to each member, parent, or guardian that included the online location of the Evidence of Coverage (EOC) as well as offered a printed copy if the member returned an attached self-addressed postage-paid postcard. The EOC contained a comprehensive set of information: benefits; member rights; grievance and appeal processes; provider selection; and email, chat, and e-visit options for medical appointments. Kaiser maintained a New Member Guide that summarized key information and phone numbers, including how to obtain appointments; support for ongoing conditions; information about preventive care, wellness, and mental health; and pharmacy benefits. Of note was the addition of a New Member Connect phone number that offered assistance with any questions.

In CY 2020, Kaiser began developing a new website designed to be more user friendly and, at the time of the audit, was in the process of updating materials to direct CHP+ members to the new site. Several of the website documents were enabled with read-aloud functionality.

Kaiser's corporate level team supported the local Complaint, Grievance, and Appeal (CGA) team. Software connectivity at a corporate level allowed all issues to be logged in a centralized system but investigated and resolved at a local level for the CHP+ population. Staff members reported that the tracking system that had been implemented since the last review contained the ability to track grievance and appeal cases from beginning to end, produce alerts for investigation and resolution time frames, and allowed for a range of reporting capabilities. Local clinical support was reportedly available in the Colorado offices or through physician consultants in the utilization management (UM) department.

Kaiser demonstrated strengths in the grievance record review with 10 of 10 records in compliance for timely grievance acknowledgement letters, nine of 10 records containing member-friendly language, and clinical reviews being conducted when applicable.

The Ethics and Compliance Program was staffed with national, regional, and local compliance officers who worked in conjunction with other departments to prevent, detect, and respond to compliance risks. Key compliance responsibilities were divided among revenue, security, and health plan operations departments with the regional compliance officer reporting directly to the chief compliance officer and regional president. The program was clearly supported by policies, procedures, and a description of other regular reports. Staff members reported that CY 2020 compliance activities focused on deploying key information in a centralized method to provide updates throughout the COVID-19 pandemic, with an emphasis on telehealth services. Kaiser staff members described the development of a "speak up" culture related to compliance efforts. This effort aimed to shift training techniques from traditional rote learning to focusing on what triggers negative behaviors and reinforcing staff member responsibilities related to program integrity. HSAG recognized this as a best practice.

Kaiser provided delegation agreements and evidence of monitoring for four delegates. Monitoring consisted of a variety of tasks including summary reports that were presented to internal committees, reports received from the delegates and reviewed by Kaiser staff members, and minutes from joint operating committees. Each of the four delegation agreements HSAG reviewed specified the activities to be delegated, the delegate's reporting responsibilities, the delegate's agreement to comply with all

applicable laws and the terms of the agreement, and remedies available to Kaiser in instances of insufficient delegate performance.

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

Member information materials, when tested, demonstrated reading levels that ranged from grade nine through eleven. Kaiser was required to implement a process to regularly review member information documents and simplify language, where possible, to ensure materials are easily understood.

The requirement for a member receiving printed materials within five-business days from a request was not included in Kaiser's desktop procedure or in the delegated vendor's distribution of materials agreement. Additionally, the Web Accessibility Evaluation Tool (WAVE) identified errors on webpages of the KP.org website, including the landing page for finding a region (i.e., Denver/Boulder) and the landing page to search for providers. Additional errors were found in Kaiser's PDF version of the provider directory, EOC, and formulary documents. Kaiser was required to revise internal procedures to ensure a five-business-day response time for requests of member information in paper format (e.g., the EOC). Kaiser was also required to develop a process for regular testing of PDF documents available to members to ensure that documents and the website content meet accessibility requirements (i.e., Section 508 of Section 504 of the Rehabilitation Act and W3C's Web Content Accessibility Guidelines).

Submitted documents contained multiple errors related to grievance and appeal systems. Kaiser was required to:

- Update member and provider-facing information to include the complete federal and CHP+ definition of "adverse benefit determination."
- Clarify that CHP+ members may file repeat grievances without restriction.
- Develop a mechanism to ensure grievance resolution language is at or near the sixth-grade reading level, to the extent possible.
- Ensure that accurate timelines for requesting an appeal are included in member communications.
- Utilize the full 10-business-day time frame or the 14-day extension available to pursue written appeals. However, due to revisions to the Medicaid and CHIP managed care regulations, written appeals are no longer required and, therefore, no CAP was needed.
- Develop a mechanism to ensure that appeal acknowledgement letters are sent in accordance with timeliness standards.
- Ensure that member communications related to the denial of an expedited resolution of an appeal accurately describe the applicable time frames. Kaiser was also required to inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited appeal request.
- Update documents related to continuation of benefits and applicable appeal and SFH time frames. However, due to revisions to the Medicaid and CHIP managed care regulations as well as the State contract, continuation of benefits was longer required and, therefore, no CAP was needed other than to remove related references.

- Clarify the terminology "denied appeal" to "appeal resolution not in favor of the member."
- Align the provider manual with the details above, specifically that the member may file a grievance at any time; who may file a grievance; that Kaiser would provide assistance; key timeline information, such as when acknowledgement letters are mailed or the extension timeline; clarify language within the "Adverse Organization Determination" section; and, due to the regulation updates, remove any reference to continuation of benefits.

Only one of the four agreements reviewed included all required provisions. Kaiser was required to amend the remaining three delegation agreements to include the required provisions that address the right of the State, CMS, HHS-OIG, Comptroller General, or other designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed, and the that the right exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, specifically the right to audit and access documents and systems at any time if there is suspicion of fraud.

Kaiser: Trended Performance for Compliance With Regulations

Table 3-27 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 3-27—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 (Includes Confidentiality) (2015–2016, 2018–2019)	60%	88%
Standard V—Member Information (2017–2018, 2020–2021)	**100%**	**90%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**68%**	**70%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**87%**	**100%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**NA****	**75%**
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	67%	89%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

Trending scores over the past two review cycles indicate that Kaiser substantially (10 percentage points or more) improved compliance within Standard VII—Provider Participation (Selection) and Program Integrity since the previous review of that standard, increasing from 87 to 100 percent compliance. Standard VI—Grievance and Appeal Systems improved slightly (less than 10 percentage points) from 68 to 70 percent compliance. Standard IX—Subcontractual Relationships and Delegation was not previously reviewed due to the 2016 managed care revisions not being applicable for CHP+ MCOs until FY 2018–2019. In addition, compliance for Standard V—Member Information decreased substantially from 100 to 90 percent.

Overall, Kaiser reached 100 percent compliance with three of the 10 standards: Standard II—Access and Availability, Standard VII—Provider Participation (Selection) and Program Integrity, and Standard VIII—Credentialing and Recredentialing. Compliance decreased from 100 to 90 percent for Standard V—Member Information, and six other standards remain below 90 percent compliance. HSAG recommends reviewing policies, procedures, and systems to address compliance, particularly in the lowest four scoring standards: Standard I—Coverage and Authorization of Services, Standard VI—Grievance and Appeal Systems, Standard IX—Subcontractual Relationships and Delegation, and Standard III—Coordination and Continuity of Care.

Validation of Network Adequacy

Kaiser: Strengths

Kaiser participated in all quarterly network adequacy reporting. While Kaiser did not meet all minimum time and distance network requirements across all counties in each county designation, Kaiser's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, Kaiser should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

Findings

Table 3-28 shows the results achieved by Kaiser for FY 2018–2019 through FY 2020–2021.

Table 3-28—Top-Box Scores for Kaiser

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Statewide Aggregate Rate
Getting Needed Care	85.5%	83.6%	78.7%	80.1%
Getting Care Quickly	90.8%	86.4%	88.1%+	86.6%
How Well Doctors Communicate	97.8%	96.3%	95.3%	94.1%
Customer Service	86.5%	89.3%+	83.6%+	87.2%
Rating of Health Plan	60.9%	61.8%	65.2%	67.0%
Rating of All Health Care	67.2%	71.3%	70.9%	72.7%
Rating of Personal Doctor	78.1%	78.1%	76.9%	77.4%
Rating of Specialist Seen Most Often	73.3%+	62.5%+	78.8%+	69.6%

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 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*
▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*
Statewide aggregate rate scores are added for reference.
↑ *Indicates the health plan's score is statistically significantly higher than the statewide aggregate rate score.*
↓ *Indicates the health plan's score is statistically significantly lower than the statewide aggregate rate score.*

Kaiser: Strengths

For the CHP+ population, Kaiser showed an upward score trend over the three-year period on one measure, *Rating of Health Plan*. In addition, Kaiser scored higher than the statewide aggregate rate in FY 2020–2021 for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often*, although none were statistically significantly higher.

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

Measures related to the access to and quality of care domains, *Getting Needed Care* and *How Well Doctors Communicate*, showed a downward score trend from FY 2018–2019 through FY 2020–2021. Also, Kaiser scored lower than the statewide aggregate rate in FY 2020–2021 for five measures: *Getting Needed Care*, *Customer Service*, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*, although none were statistically significantly lower. Performance for the *Getting*

Needed Care measure may be related to a variety of factors including whether parents/caretakers felt they were able to get care and appointments as soon as their child needed. Performance for the *How Well Doctors Communicate* measure may be related to a variety of factors including whether parents/caretakers felt their child's personal doctor explained things in an understandable way, listened carefully to them, and showed respect for what they had to say. Performance for the *Customer Service* measure may be related to a variety of factors including whether parents/caretakers felt they received the information or help they needed and were treated with courtesy and respect by the staff. Performance for the *Rating of Health Plan* measure may be related to a variety of factors including whether parents/caretakers felt they received quality, timely, and accessible services overall. Performance for the *Rating of All Health Care* measure may be related to a variety of factors including whether parents/caretakers felt they received the care, tests, or treatment as soon as their child needed. Performance for the *Rating of Personal Doctor* measure may be related to a variety of factors including whether parents/caretakers felt their child's doctor spent enough time with their child, discussed how their child is feeling, and seemed up to date about the care their child received from other doctors. HSAG recommends that Kaiser explore what may be driving a decrease in the score for these measures from FY 2018–2019 to FY 2020–2021 and develop initiatives for improvement, where appropriate.

Rocky Mountain Health Plans

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-29 and Table 3-30 display the FY 2020–2021 validation findings for RMHP's *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. During FY 2020–2021, RMHP completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, RMHP defined the eligible population, narrowed focus, and goals for the PIP. These components were summarized in SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statements. The SMART aim statements that RMHP defined for the two PIP outcome measures in Module 1 are provided in Table 3-29.

Table 3-29—PIP Initiation for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP Members 12 years of age or older from 3.5% to 25.0%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP Members 12 years of age or older who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days to the established benchmark of 46.89%.

In Module 2—Intervention Determination, RMHP conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, RMHP updated key driver diagrams to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goals defined in Module 1. The key drivers and potential interventions identified by RMHP in Module 2 are summarized for the two PIP outcome measures in Table 3-30. The PIP had not progressed to the point of deploying and testing interventions. The interventions that RMHP ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-30—Intervention Determination for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, RMHP will continue testing interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP through the end of FY 2021–2022. RMHP will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

RMHP: Strengths

The validation findings suggest that RMHP was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. RMHP also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in screening members for depression and providing timely follow-up services for members who screen positive for depression. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

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

As RMHP continues the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- RMHP should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as RMHP progresses through determining and testing interventions.
- RMHP should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, RMHP should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to RMHP's HEDIS MY 2020 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 3-31 shows the performance measure results for RMHP for HEDIS MY 2018 through HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-31—Performance Measure Results for RMHP

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	57.08%	21.00%	60.79%^	<10th
Combination 3	57.08%	20.50%	59.47%^	<10th
Combination 4	54.42%	20.50%	58.59%^	<10th
Combination 5	54.87%	16.00%	54.63%^	10th–24th
Combination 6	41.15%	12.00%	46.26%^	50th–74th
Combination 7	52.21%	16.00%	53.74%^	10th–24th
Combination 8	39.38%	12.00%	45.81%^	50th–74th
Combination 9	39.82%	11.00%	42.29%^	50th–74th
Combination 10	38.05%	11.00%	41.85%^	50th–74th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	57.67%	62.86%	63.47%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	18.33%	20.32%	28.44%^	10th–24th
Well-Child Visits in the First 30 Months of Life[2]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	22.69%	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	75.24%	—
Child and Adolescent Well-Care Visits[2]				
Total	—	—	45.15%	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	4.83%	8.53%	13.63%^	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Counseling for Nutrition—Total	23.00%	28.21%	25.20%^^	<10th
Counseling for Physical Activity—Total	5.50%	7.89%	6.52%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	33.57%	30.67%	30.77%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.19%	75th–89th
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication[1]				
Initiation Phase	53.33%	55.88%	51.22%	75th–89th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose Testing—Total	—	NA	NA	—
Cholesterol Testing—Total	—	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Testing for Pharyngitis[1]				
Ages 3 to 17 Years	—	77.29%	86.82%^	75th–89th
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	—	94.78%	95.86%	75th–89th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	—	69.66%	77.00%	75th–89th
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	18.38	18.93	13.14	≥90th
Outpatient Visits—Total	211.60	222.08	186.23	<10th
Inpatient Utilization—General Hospital/Acute Care				
Total Discharges per 1,000 Member Months (Total Inpatient)	0.75	0.68	0.62	<10th
Total Average Length of Stay (Total Inpatient)	4.37	3.67	2.84	<10th

Performance Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Percentile Ranking
Total Discharges per 1,000 Member Months (Medicine)	0.49	0.50	0.47	<10th
Total Average Length of Stay (Medicine)	3.27	3.02	2.84	<10th
Total Discharges per 1,000 Member Months (Surgery)	0.21	0.17	0.14	<10th
Total Average Length of Stay (Surgery)	7.46†	5.76†	2.88†	<10th
Total Discharges per 1,000 Member Months (Maternity)	0.10	0.03	0.02	<10th
Total Average Length of Stay (Maternity)	2.33†	2.00†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.39	0.41	0.41	≥90th
Average Days Supplied per Antibiotic Script—Total	10.20	20.51	10.73	<10th
Average Scripts PMPY for Antibiotics of Concern	0.14	0.14	0.12	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	35.98%	33.22%	29.98%	≥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 HEDIS MY 2020 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 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 MY 2018 or HEDIS MY 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 MY 2020 measure rates were determined to be high-performing rates for RMHP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS MY 2019; or ranked between the 50th and 74th percentiles with a significant improvement in performance from HEDIS MY 2019):

- *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years*
- *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*
- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*

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

For HEDIS MY 2020, RMHP demonstrated strong performance for the *Childhood Immunization Status* measure by ranking above the 50th percentile for four measure indicator rates and demonstrated a statistically significant improvement for these four measure indicator rates from the previous year. Additionally, RMHP demonstrated appropriate management of members with respiratory conditions and continued to ensure young women are not being screened unnecessarily for cervical cancer.

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

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

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Childhood Immunization Status—Combinations 2*, *3*, *4*, *5*, and *7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *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*

RMHP's performance demonstrated opportunities to improve rates for children and adolescents receiving vaccinations, with rates for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* and *Childhood Immunization Status—Combinations 2*, *3*, *4*, *5*, and *7* measure indicators falling below the 25th percentile. However, six of seven (85.7 percent) measure indicator rates demonstrated a statistically significant improvement from the previous year. Further, all three measure indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure fell below the 10th percentile; however, the *BMI Percentile Documentation—Total* measure indicator demonstrated a statistically significant decline in performance from the previous year. HSAG recommends that the MCO review the activities of the Pediatrics Team QIC subcommittee and determine the effectiveness of the interventions that RMHP has created. Since the committee was formed in 2021 and *Immunizations for Adolescents* and *Childhood Immunization Status* were focused measures, RMHP should have a monitoring mechanism in place that can be reviewed on an ongoing basis to monitor how successful the committee has been.

Assessment of Compliance With CHIP Managed Care Regulations

RMHP Overall Evaluation

Table 3-32 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 2020–2021.

Table 3-32—Summary of RMHP Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	21	20	19	1	0	1	95%
Standard VI—Grievance and Appeal Systems	34	34	33	1	0	0	97%
Standard VII—Provider Participation (Selection) and Program Integrity	16	16	15	1	0	0	94%
Standard IX—Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**74**	**70**	**4**	**0**	**1**	**95%***

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

Table 3-33 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 2020–2021.

Table 3-33—Summary of RMHP Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	48	39	38	1	9	97%
Appeals	60	52	52	0	8	100%
Totals	**108**	**91**	**90**	**1**	**17**	**99%***

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

RMHP: Strengths

RMHP's policies described the requirements for developing member information documents, which included font size, reading level, translation, and availability of auxiliary aids and services. Written materials critical to obtaining services were required to be reviewed by RMHP's member advisory council for feedback. The RMHP CHP+ Benefits Booklet was written in easy-to-understand language, included the required tagline and font sizes, and described how to access translation and auxiliary services. Members received an introductory phone call to provide assistance and answer questions. RMHP's website was easy to navigate and offered adjustable font size and few to no accessibility errors.

The grievance system included policies and procedures that addressed State and federal requirements regarding member grievance, appeal, and SFH processes and timelines. Appeals and grievance policy and procedure documents reflected processing requirements and time frames for receiving, acknowledging, and resolving grievances and appeals, and record review samples demonstrated adherence to required member notices. Staff members described regular audits to monitor compliance.

RMHP described a provider network that rewarded high performance providers through a variety of reimbursement strategies and ultimately responded to the unique needs of its members. Staff members also cited a grassroots approach to outreach providers, which included attending a variety of local community meetings and events to reduce the stigma about the CHP+ program through "myth busting" informational sessions.

Compliance policies, procedures, and other submitted documents demonstrated a robust program integrity system, which was aligned with federal and State regulations. The compliance committee reviewed risk assessments and assigned priorities based on compliance and/or business risks. Additionally, a compliance scorecard was generated by United Healthcare (UHC). The Member Verification of Services procedure included claims reports, confidence interval methodology, and sampled both adults and children.

RMHP maintained a set of policies that described the mechanisms in place for delegation and oversight. The department associated with each delegated function was responsible for oversight activities. The majority of delegates performed credentialing and recredentialing; however, other delegated functions included pharmacy benefit management, behavioral health services, and UM.

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

Due to December 2020 Medicaid and CHIP managed care regulation revisions and resultant State contract revisions, RMHP was required to remove any references to continuation of benefits from its CHP+ policies, procedures, and member and provider materials.

Three of the sample appeal cases reviewed were provider administrative issues that were misclassified as member appeals. RMHP was required to develop specific criteria for defining provider versus member appeals to assist staff members to accurately identify when an appeal should or should not involve the member.

The Professional Services Agreement, Physicians Medical Services Agreement, and the BH Provider Manual all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was listed under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that included a citation (Colorado Revised Statutes [C.R.S.] 25.5-4-301[1]), which was not entirely accurate for CHP+ members. The paragraph did not include additional context regarding instances in which CHP+ members may have a copay or out-of-network liabilities. RMHP was required to update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommended using 42 CFR §438.106 language as a basis for these updates, with additional consideration to the individual contract language.

Some delegation subcontracts did not include language to grant the HHS-OIG, Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor for up to 10 years. RMHP was required to update the delegated credentialing agreements to include all required language specified in 42 CFR §438.230(c)(3).

RMHP: Trended Performance for Compliance With Regulations

Table 3-34 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 3-34—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 (Includes Confidentiality) (2015–2016, 2018–2019)	80%	88%
Standard V—Member Information (2017–2018, 2020–2021)	**100%**	**95%**
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	**82%**	**97%**
Standard VII—Provider Participation (Selection) and Program Integrity (2017–2018, 2020–2021)	**93%**	**94%**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)	100%	100%
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	**NA****	**75%**

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)	100%	83%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

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

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

Trending scores over the past two review cycles indicate that RMHP maintained 100 percent compliance with two standards, increased scores for three standards, and decreased in compliance scores for four standards. Out of the four standards reviewed in FY 2020–2021, two standards showed improved scores: Standard VI—Grievance and Appeal Systems improved from 82 to 97 percent and Standard VII—Provider Participation (Selection) and Program Integrity improved by 1 percentage point from 93 to 94 percent. Standard IX—Subcontractual Relationships and Delegation was not previously reviewed in FY 2017–2018 due to Medicaid and CHIP managed care revisions not being applicable to the CHP+ MCOs until FY 2018–2019. RMHP received a compliance score of 75 percent for Standard IX—Subcontractual Relationships and Delegation in FY 2020–2021, based on meeting three of the four required elements. 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 resultant design of compliance monitoring tools) may have impacted comparability of the compliance results over review periods.

HSAG recommends reviewing policies, procedures, and systems to target efforts to improve compliance within standards scoring under 90 percent: Standard IX—Subcontractual Relationships and Delegation, Standard III—Coordination and Continuity of Care, Standard X—Quality Assessment and Performance Improvement, and Standard IV—Member Rights and Protections.

Validation of Network Adequacy

RMHP: Strengths

RMHP participated in all quarterly network adequacy reporting. While RMHP did not meet all minimum time and distance network requirements across all counties in each county designation, RMHP's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, RMHP should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

Findings

Table 3-35 shows the results achieved by RMHP for FY 2018–2019 through FY 2020–2021.

Table 3-35—Top-Box Scores for RMHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score	FY 2020–2021 Score	FY 2020–2021 Statewide Aggregate Rate
Getting Needed Care	90.1%	85.2%	85.1%	80.1%
Getting Care Quickly	93.3%	94.9%	89.6% ▼	86.6%
How Well Doctors Communicate	97.1%	97.2%	97.5%	94.1%
Customer Service	87.9%	84.3%+	89.4%+	87.2%
Rating of Health Plan	68.3%	69.3%	70.2%	67.0%
Rating of All Health Care	67.7%	66.0%	74.3% ▲	72.7%
Rating of Personal Doctor	71.2%	72.0%	74.1%	77.4%
Rating of Specialist Seen Most Often	82.9%+	64.8%+	73.8%+	69.6%

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 2020–2021 score is statistically significantly higher than the FY 2019–2020 score.*

▼ *Indicates the FY 2020–2021 score is statistically significantly lower than the FY 2019–2020 score.*

Statewide aggregate rate scores are added for reference.

↑ *Indicates the health plan's score is statistically significantly higher than the statewide aggregate rate score.*

↓ *Indicates the health plan's score is statistically significantly lower than the statewide aggregate rate score.*

RMHP: Strengths

For the CHP+ population, RMHP scored higher than the statewide aggregate rate in FY 2020–2021 for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*, although none were statistically significantly higher. RMHP scored statistically significant higher in FY 2020–2021 than in FY 2019–2020 on *Rating of All Health Care*. In addition, RMHP showed an upward score trend over the three-year period on the following three measures: *How Well Doctors Communicate*, *Rating of Health Plan*, and *Rating of Personal Doctor*.

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

For the CHP+ population, RMHP scored statistically significantly lower in FY 2020–2021 than in FY 2019–2020 on one measure related to the quality and timeliness of care domains, *Getting Care Quickly*. In addition, RMHP showed a downward score trend over the three-year period on one measure related to the quality of and access to care domains, *Getting Needed Care*. Also, RMHP scored lower than the statewide aggregate rate in FY 2020–2021 on one measure, *Rating of Personal Doctor*, although it was not statistically significantly lower. Performance for the *Getting Needed Care* measure may be related to a variety of factors including whether parents/caretakers felt they were able to get care and appointments as soon as their child needed. Performance for the *Getting Care Quickly* measure may be related to a variety of factors including whether parents/caretakers felt their child received the services and appointments they needed in a timely manner. Performance for the *Rating of Personal Doctor* measure may be related to a variety of factors including whether parents/caretakers felt their child's doctor explained things in an understandable way, listened carefully, showed respect, spent enough time with their child, discussed how their child is feeling, and seemed up to date about the care their child received from other doctors. HSAG recommends that RMHP explore what may be driving a decrease in the scores for these measures and develop initiatives for improvement, where appropriate.

DentaQuest

Validation of Performance Improvement Projects

Validation Activities and Interventions

Table 3-36 and Table 3-37 display the FY 2020–2021 validation findings for DentaQuest's *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP. During FY 2020–2021, DentaQuest completed Module 1—PIP Initiation and Module 2—Intervention Determination. In Module 1, DentaQuest defined the eligible population, narrowed focus, and goal for the PIP. These components were summarized in a SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) aim statement, which is provided in Table 3-36.

Table 3-36—PIP Initiation for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Dental Service Utilization Among 3–5-Year-Olds Residing in Weld County	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members aged 3–5 who reside in Weld County, from 45.47% to 49.3%.

In Module 2—Intervention Determination, DentaQuest conducted process mapping and FMEA to identify potential interventions to test for the PIP. At the completion of Module 2, DentaQuest updated the key driver diagram to reflect the current key drivers and potential interventions identified to support achievement of the SMART Aim goal defined in Module 1. The key drivers and potential interventions identified by DentaQuest in Module 2 are summarized in Table 3-37. The PIP had not progressed to the point of deploying and testing interventions. The interventions that DentaQuest ultimately selects to test for the PIP will be reported in next year's technical report as part of the validation findings for FY 2021–2022.

Table 3-37—Intervention Determination for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Preliminary Key Drivers	• Awareness of dental benefits. • Access to dental services. • Provider participation to encourage benefit utilization. • Caregiver understanding of the importance of oral health in primary teeth.
Potential Interventions	• Provide outreach and education to member/caregiver on dental benefits and the importance of early oral health. • Collaborate with community partners to distribute dental benefit information. • Partner with network dental providers to offer non-traditional modes of dental care. • Document and distribute information on flexible dental provider office hours.

	• Notify member's assigned dental provider if no dental service has been received in the past 12 months. • Implement a dental home care model for Colorado CHP+ members. • Partner with schools to engage children and parents in oral health and prevention.

Validation Status

The PIP did not progress to receiving a validation status in FY 2020–2021. Following the rapid-cycle PIP process, which spans multiple fiscal years, DentaQuest will continue testing interventions for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP through the end of FY 2021–2022. DentaQuest will submit final intervention testing results and PIP outcomes for Module 4—PIP Conclusions in FY 2022–2023. HSAG will validate Module 4—PIP Conclusions and assign an overall PIP validation status to the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP in FY 2022–2023; the validation status will be reported in the FY 2022–2023 EQR technical report.

DentaQuest: Strengths

The validation findings suggest that DentaQuest was successful in building a QI team and identifying potential collaborative partnerships with targeted providers. DentaQuest also successfully used QI science-based tools such as process mapping and FMEA to thoroughly examine gaps and/or failures in the processes involved in ensuring all children enrolled in the health plan under the age of 21 receive at least one dental service within the reporting year. These tools allowed the health plan to identify potential interventions to address high-priority process flaws and facilitate improvement in PIP outcomes over time.

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

As DentaQuest continues the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP in the next fiscal year and selects interventions to test through PDSA cycles, HSAG recommends the following:

- DentaQuest should review and update the key driver diagrams after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as DentaQuest progresses through determining and testing interventions.
- DentaQuest should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, DentaQuest should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Validation of Performance Measures

Compliance With Information Systems Standards

According to DentaQuest's HEDIS MY 2020 Compliance Audit Report, DentaQuest was fully compliant with all IS standards relevant to the scope of the PMV performed by the PAHP's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted DentaQuest's HEDIS performance measure reporting.

Performance Measure Results

Table 3-31 shows the performance measure results for DentaQuest for HEDIS MY 2020, along with the percentile rankings for each HEDIS MY 2020 rate.

Table 3-38—Performance Measure Results for DentaQuest

Performance Measure	Eligible Population	HEDIS MY 2020 Rate	Percentile Ranking
Dental			
Annual Dental Visit			
Ages 2 to 3 Years	4,066	51.30%	50th–74th
Ages 4 to 6 Years	7,527	64.45%	25th–49th
Ages 7 to 10 Years	10,405	67.95%	25th–49th
Ages 11 to 14 Years	11,074	62.53%	25th–49th
Ages 15 to 18 Years	10,022	51.34%	25th–49th
Ages 19 to 20 Years	172	34.88%	25th–49th
Total	43,266	60.41%	50th–74th

DentaQuest: Strengths

DentaQuest was above the 50th percentile for the *Annual Dental Visit—Ages 2 to 3 Years* and *Total* measure indicators.

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

DentaQuest fell below the 50th percentile for five of the six age stratifications reported. HSAG recommends that DentaQuest assess barriers to dental visits for children and adolescents. DentaQuest should develop interventions to improve rates in these access to care indicators.

Assessment of Compliance With CHIP Managed Care Regulations

DentaQuest Overall Evaluation

Table 3-39 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 2020–2021.

Table 3-39—Summary of DentaQuest Scores for the FY 2020–2021 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard V—Member Information	20	19	12	7	0	1	63%
Standard VI—Grievance and Appeal Systems	34	34	25	9	0	0	74%
Standard VII—Provider Participation (Selection) and Program Integrity	16	15	13	2	0	1	87%
Standard IX—Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Totals	**74**	**72**	**54**	**18**	**0**	**2**	**75%***

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

Table 3-40 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 2020–2021.

Table 3-40—Summary of DentaQuest Scores for the FY 2020–2021 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	50	47	3	10	94%
Appeals	60	58	49	9	2	84%
Totals	**120**	**108**	**96**	**12**	**12**	**89%***

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

DentaQuest: Strengths

DentaQuest used a variety of mechanisms to assist members in understanding the benefits and services available. DentaQuest established a health literacy policy requiring the use of plain language, cultural and linguistic appropriateness, and a sixth-grade reading level to guide the development of member information materials. DentaQuest's website offered adjustable text size and a Spanish language option. The member handbook contained essential benefit summary information, informed members of the availability of written materials, along with information on how to access alternative formats, translation services, and auxiliary aids and services for members with special needs—all free of charge.

Grievance and appeal staff members were located in Milwaukee, Wisconsin, but included designated staff members assigned to the Colorado region. Policies, procedures, and member communications included Colorado-specific timelines and correct federal definitions based on recent work on a CAP, which stemmed from the FY 2019–2020 compliance review. The grievance and appeal data system included notes, calls, due dates, and correspondence from members as well as DentaQuest staff members. Grievance samples demonstrated that grievance acknowledgment letters reviewed were sent within two working days, and that resolution letters reviewed were easy to understand. Both the grievance and appeal resolution letters included the required content. HSAG identified one record in which DentaQuest reviewed a standard appeal request and determined that an expedited appeal was necessary due to the member's report of pain. HSAG recognized this as a best practice for administrative staff members to advocate on behalf of the member to trigger further evaluation and meet the member's immediate needs.

The network relations team for the West/Midwest region was the main point of contact for providers, in addition to some additional support provided through the contracting team, credentialing team, self-service support through the Web portal, and general support through customer service representatives. Policies and procedures related to human resources (HR) and credentialing described measures to ensure excluded entities or providers were not employed by DentaQuest. Submitted documents outlined how accounting and HR worked together alongside the compliance department to ensure all appropriate checks were conducted pre-hire, monthly, and ongoing as appropriate.

The general all-staff compliance training included instructions for how to promptly report any suspected fraud, waste, or abuse. In addition to the new employee onboarding training and annual refreshers, staff members reported that the board of directors also received a specialized training annually, which was refreshed with unique topics based on the board's fiduciary duties. Compliance monitoring was described to occur routinely and consisted of operations meetings, contract monitoring, and feedback from multiple internal departments. Subject matter experts identified, discussed, and mitigated risks; this information passed through the compliance operational meeting, up to the compliance committee, and then to the board of directors, who reviewed and provided additional recommendations when appropriate. In addition to routine analysis of claims data, anomalous utilization, and billing patterns, employee feedback was also considered.

Delegate agreements included services such as printing materials, credentialing, and monitoring responsibilities related to ownership and disclosure. The Vendor Management Program document was used

internally as a procedural reference and distributed externally to vendors in order to inform delegates about the contracting process and expectations. In addition to this document, DentaQuest used a contract repository and project management program. Each delegate underwent a "scorecard" process in which performance, engagement, communication, and innovation were measured for a total score out of 10 possible points. Sample scorecards reviewed had scores of seven or above, and staff members reported that if a score fell below the threshold of seven, additional conversations and possible actions may be pursued. DentaQuest did not have any open CAPs for its delegates; however, staff members were able to provide a sample template of possible corrective actions and follow-ups that would be followed, if necessary.

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

Related to the Member Information standard, DentaQuest was required to:

- Complete the tagline and ensure the use of required font sizes in the member handbook and welcome letter.
- Develop a mechanism to notify members that electronic information is available in paper form without charge upon request and is provided within five business days, and a mechanism to ensure the timely delivery of such materials.
- Establish a mechanism to inform members of provider termination within 15 days of the termination notice.
- Ensure all required member rights are listed in the member handbook, and ensure the member rights listed in the handbook and the member rights accessible through the Dental Program Rights and Responsibilities link on the website are consistent.
- Revise member handbook language to inform the member that prior authorization is not required for emergency services, and that the member has the right to seek services from any dental or emergency provider to obtain emergency care if needed.
- Add information to the member handbook regarding how and where to access information about other healthcare services that are available under the State plan but not covered under the CHP+ managed care contract, such as a link to the Department's website section containing other types of benefit information. DentaQuest was also required to add information to the member handbook instructing members how to report suspected fraud or abuse and add the telephone number to contact medical management and any other departments that provide services for members.

Related to the Grievance and Appeal Systems standard, DentaQuest was required to:

- Develop a mechanism to ensure that all grievance resolution letters are sent within 15 working days following the receipt of the grievance.
- Ensure that all appeals are acknowledged in writing within two working days of the receipt of the appeal.
- Revise its Member Appeals policy to include the requirement that the notice to a member denying an expedited review of an appeal will inform the member that the member has the right to file a grievance if they disagree with the decision to deny expedition.

- Develop a mechanism to ensure that all appeal resolution letters are sent within the required 10-working-day time frame.
- Clarify within the policy/procedure, member handbook, and provider manual that the time frame is calculated from the notice of appeal resolution.
- Ensure that grievance and appeal records are accurately maintained.
- Notify providers at the time of contracting (through the Office Reference Manual [ORM] or other means) about the member grievance and appeal system and that the information is accurate, and must clarify or include the following:
  - Providers, with written consent, may file a grievance, an appeal, and may request an SFH on behalf of the member.
  - Peer-to-peer reconsiderations must occur prior to the member receiving an NABD, otherwise the appeal process must be conducted with members being parities to the appeal.
  - Members or their representatives may appeal pre-service as well as claims denials.
  - Appeals must be resolved within 10 business days following the receipt of the appeal (not from when documents are received) unless an extension is requested in writing that meets the content requirements.
  - Grievances and appeals may be filed orally or in writing.
  - SFHs must be requested within 120 days from the date of the notice of appeal resolution unless the member has received continued services during the appeal and is requesting continued services during the SFH, in which case the SFH and the services must be requested within 10 days following the notice of appeal resolution.
  - Information about requesting expedited DentaQuest-level appeals.

Program integrity staff members were not able to describe or show evidence of a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. DentaQuest was required to develop and implement a method, such as sampling, to determine whether services represented by providers were in fact received by members.

DentaQuest did not maintain a procedure regarding written disclosure of prohibited affiliations, specifically, how to report to the State. Similarly there were no details or procedures regarding how DentaQuest provided ownership and control disclosures to the State. DentaQuest was required to update or create a procedure for how written disclosures of prohibited affiliations and written disclosure of ownership and control are reported to the State.

DentaQuest: Trended Performance for Compliance With Regulations

As FY 2019–2020 was the initial year of DentaQuest's CHP+ contract, no data were available for trending performance between compliance review cycles.

Validation of Network Adequacy

DentaQuest: Strengths

DentaQuest participated in all quarterly network adequacy reporting, and HSAG agreed with 100 percent of the PAHP's quarterly geoaccess compliance results for enrolled members living in frontier counties, 98.1 percent of the PAHP's results for members living in rural counties, and 82.1 percent of PAHP's results for members living in urban counties. Among urban counties, 100 percent of the dental results have 90 percent or more of the PAHP's members with access in the minimum time or distance requirement. These results indicate the PAHP's ability to provide validated result for frontier and rural counties.

While DentaQuest did not meet all minimum time and distance network requirements across all counties in each county designation, DentaQuest's NAV report to the Department included the health plan's self-reported description of its methods for ensuring access to care for members residing beyond the minimum times or distances.

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

As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional verification processes into the quarterly NAV to improve data quality.

To support accurate network information that facilitates members' access to care, DentaQuest should verify that network data shown in its online provider directory aligns with the network data submitted to the Department for the quarterly network adequacy reports.

CAHPS Surveys

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

Validation of Performance Improvement Projects

Table 4-1 shows the FY 2020–2021 statewide PIP results for the CHP+ health plans.

Table 4-1—FY 2020–2021 PIP Results for the CHP+ Health Plans

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

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2020–2021 validation cycle.*

During FY 2020–2021, the CHP+ health plans initiated new rapid-cycle PIPs. All CHP+ health plans except DentaQuest, the dental PAHP, initiated *Depression Screening and Follow-Up After a Positive Depression Screen* PIPs, a state-mandated topic selected by the Department. 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, with a narrowed focus on members 3 to 5 years of age in a specific county. The PIPs run on an 18-month schedule and will continue into the next fiscal year. The PIPs will be evaluated on outcomes and receive a final validation status after the health plans complete all four modules of the rapid-cycle PIP process and submit final documentation for validation.

During the FY 2020–2021 validation cycle, the health plans received training and technical assistance on the rapid-cycle PIP process and developed the foundation of the projects in the first two modules of the process. The health plans submitted documentation on Module 1 and Module 2 for a total of six PIPs. HSAG provided feedback to the health plans on the initial submissions and the health plans revised the module documentation and resubmitted Module 1 and Module 2 until all criteria were achieved. Five of the six health plans passed Module 1 and Module 2, achieving all validation criteria

for the first two modules for the PIPs. The remaining health plan, FHP, passed Module 1 and initiated Module 2, but did not pass the second module until FY 2021–2022.

Statewide Conclusions and Recommendations for PIPs

The FY 2020–2021 validation findings for all six PIPs suggested that all health plans designed methodologically sound rapid-cycle PIPs. The health plans used data to identify a narrowed focus for each project, convened PIP teams to include necessary internal and external partners, established a goal for improvement, and defined a measure and data collection plan to evaluate progress toward achieving the goal. In the next fiscal year, the health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. As the health plans continue working on the PIPs, HSAG recommends the following:

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

Validation of Performance Measures

In Table 4-2, MCO-specific and statewide weighted averages are presented for the CHP+ MCOs for HEDIS MY 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 4-2—MCO and Statewide Results for HEDIS MY 2020

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Pediatric Care						
Childhood Immunization Status						
Combination 2	74.12%	81.94%	NA	68.13%	60.79%	70.56%
Combination 3	72.50%	81.94%	NA	67.50%	59.47%	69.20%
Combination 4	69.87%	81.94%	NA	67.50%	58.59%	67.30%
Combination 5	67.24%	75.00%	NA	63.75%	54.63%	64.18%
Combination 6	58.14%	66.67%	NA	52.50%	46.26%	55.09%
Combination 7	65.12%	75.00%	NA	63.75%	53.74%	62.62%
Combination 8	56.32%	66.67%	NA	52.50%	45.81%	53.80%
Combination 9	55.11%	63.89%	NA	49.38%	42.29%	51.97%
Combination 10	53.69%	63.89%	NA	49.38%	41.85%	50.95%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	76.97%	88.00%	43.40%	85.81%	63.47%	76.12%
Combination 2 (Meningococcal, Tdap, HPV)	41.81%	54.00%	22.64%	59.46%	28.44%	42.47%
Well-Child Visits in the First 30 Months of Life						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	54.92%	64.52%	NA	51.35%	22.69%	48.90%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	75.31%	66.18%	NA	61.18%	75.24%	73.12%
Child and Adolescent Well-Care Visits						
Total	47.69%	46.11%	32.50%	34.60%	45.15%	45.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	15.33%	63.96%	6.18%	93.52%	13.63%	24.29%
Counseling for Nutrition—Total	10.66%	70.36%	2.56%	89.31%	25.20%	22.75%
Counseling for Physical Activity—Total	7.62%	69.92%	3.62%	89.31%	6.52%	17.76%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Access to Care						
Prenatal and Postpartum Care^						
Timeliness of Prenatal Care	—	—	—	—	—	58.45%
Postpartum Care	—	—	—	—	—	53.32%
Annual Dental Visit^^						
Total	—	—	—	—	—	60.41%
Preventive Screening						
Chlamydia Screening in Women						
Ages 16 to 20 Years	33.74%	44.29%	NA	45.83%	30.77%	35.29%
Non-Recommended Cervical Cancer Screening in Adolescent Females*						
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.04%	0.00%	0.00%	0.00%	0.19%	0.05%
Mental/Behavioral Health						
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	33.78%	NA	NA	NA	51.22%	36.45%
Continuation and Maintenance Phase	46.94%	NA	NA	NA	NA	50.85%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
Blood Glucose Testing—Total	40.80%	NA	NA	NA	NA	44.44%
Cholesterol Testing—Total	19.20%	NA	NA	NA	NA	25.31%
Blood Glucose and Cholesterol Testing—Total	19.20%	NA	NA	NA	NA	25.31%
Respiratory Conditions						
Appropriate Testing for Pharyngitis						
Ages 3 to 17 Years	83.84%	85.07%	77.66%	89.70%	86.52%	84.56%
Appropriate Treatment for Upper Respiratory Infection						
Ages 3 Months to 17 Years	92.12%	98.49%	93.96%	97.75%	95.86%	93.36%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis						
Ages 3 Months to 17 Years	70.30%	NA	NA	97.06%	77.00%	72.27%
Asthma Medication Ratio						
Ages 5 to 11 Years	84.12%	NA	NA	NA	NA	84.04%
Ages 12 to 18 Years	72.80%	NA	NA	NA	NA	77.96%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Use of Services†						
Ambulatory Care (Per 1,000 Member Months)						
*Emergency Department Visits—Total**	17.24	13.67	12.71	14.61	13.14	16.07
Outpatient Visits—Total	177.19	127.95	141.10	108.70	186.23	167.24
Inpatient Utilization—General Hospital/Acute Care						
Total Discharges per 1,000 Member Months (Total Inpatient)	0.73	0.69	0.50	0.49	0.62	0.68
Total Average Length of Stay (Total Inpatient)	3.30	2.30	2.33†	3.22	2.84	3.15
Total Discharges per 1,000 Member Months (Medicine)	0.56	0.50	0.17	0.34	0.47	0.51
Total Average Length of Stay (Medicine)	3.26	2.00†	1.33†	3.45	2.84	3.13
Total Discharges per 1,000 Member Months (Surgery)	0.15	0.13	0.28	0.14	0.14	0.15
Total Average Length of Stay (Surgery)	3.54	3.57†	2.80†	2.77†	2.88†	3.34
Total Discharges per 1,000 Member Months (Maternity)	0.06	0.10	0.11	0.02	0.02	0.05
Total Average Length of Stay (Maternity)	2.69†	2.00†	3.00†	2.00†	2.00†	2.55†
Antibiotic Utilization*						
Average Scripts PMPY for Antibiotics	0.21	0.12	0.27	0.17	0.41	0.23
Average Days Supplied per Antibiotic Script—Total	11.45	12.43	9.65	14.16	10.73	11.47
Average Scripts PMPY for Antibiotics of Concern	0.07	0.03	0.10	0.04	0.12	0.07
Percentage of Antibiotics of Concern of All Antibiotic Scripts	30.66%	25.52%	38.94%	25.00%	29.98%	30.09%

** For this indicator, a lower rate indicates better performance.*
— Indicates that the MCOs were not required to report this measure for HEDIS MY 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.
^^DentaQuest is the only CHP+ health plan required to report the Annual Dental Visit measure.

Statewide Strengths

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

- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*
- *Childhood Immunization Status—Combinations 5 through 10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

The HEDIS MY 2020 statewide weighted averages for the *Childhood Immunization Status—Combinations 5 through 10* and *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicators within the Pediatric Care domain demonstrated strong performance, as all measure rates statistically significantly improved in HEDIS MY 2020.

The HEDIS MY 2020 statewide weighted average and rates for four of the 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.

The HEDIS MY 2020 statewide weighted average for the *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years* measure indicators in the Respiratory Conditions domain exceeded the 90th percentile. The A*sthma 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).

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

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

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Immunization for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

- *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*

Statewide performance for HEDIS MY 2020 demonstrated opportunities to improve the access to preventive care and services for members, including well-care visits, immunizations, chlamydia screening, follow-up care for members prescribed ADHD medications, and monitoring for children and adolescents on antipsychotics. All three indicators for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure had a statistically significant decline in performance from the previous year and all three fell below the 25th percentile. HSAG recommends that the Department and the MCOs work together to identify barriers for members getting tested (e.g., determine whether the COVID-19 public health emergency created barriers for testing). Additionally, HSAG recommends that the Department and the MCOs do the following to ensure proper metabolic testing is completed for members:

- Educate members on the importance of consistent testing.
- Ensure members have the appropriate transportation to and from appointments.
- Monitor members' weight and blood pressure to identify significant changes.
- Coordinate care between the members' PCPs and behavioral health providers.

Assessment of Compliance With CHIP Managed Care Regulations

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

Description of Standard	COA	DHMP	FHP	Kaiser	RMHP	Denta-Quest*	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 (Includes Confidentiality) (2018–2019)	88%	100%	88%	88%	88%	NA	90%
Standard V—Member Information (2020–2021)	**95%**	**95%**	**67%**	**90%**	**95%**	**63%**	**84%**
Standard VI—Grievance and Appeal Systems (2020–2021)	**88%**	**94%**	**53%**	**70%**	**97%**	**74%**	**79%**
Standard VII—Provider Participation (Selection) and Program Integrity (2020–2021)	**100%**	**93%**	**75%**	**100%**	**94%**	**87%**	**91%**
Standard VIII—Credentialing and Recredentialing (2018–2019)	100%	100%	86%	100%	100%	NA	97%
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	**100%**	**75%**	**50%**	**75%**	**75%**	**100%**	**79%**
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 2020–2021.

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

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

Record Review	COA	DHMP	FHP	Kaiser	RMHP	Denta-Quest	Statewide Average
Appeals (2020–2021)	**95%**	**100%**	**33%**	**96%**	**100%**	**84%**	**85%**
Credentialing (2018–2019)	100%	100%	97%	100%	100%	NA*	99%
Denials (2019–2020)	66%	83%	75%	66%	97%	65%	75%
Grievances (2020–2021)	**96%**	**78%**	**NA**	**98%**	**97%**	**94%**	**93%**
Recredentialing (2018–2019)	100%	100%	100%	100%	100%	NA*	100%

Bold text indicates standards reviewed by HSAG during FY 2020–2021.

**DentaQuest began its contract in FY 2019–2020 and has not yet been reviewed for credentialing and recredentialing standards.*

Statewide Conclusions and Strengths Related to Compliance With Regulations

Based on the previous three years of compliance reviews (FY 2018–2019, FY 2019–2020, and FY 2020–2021) the CHP+ health plans maintained high scores (90 percent compliance or higher) in four of the 10 standards and three of the five record review topics. Notably, health plans demonstrated high levels of compliance with credentialing and recredentialing requirements, which averaged 97 percent compliance and record review scores reached 99 and 100 percent compliance respectively across the CHP+ health plans during FY 2018–2019.

During the FY 2020–2021 review period, health plans received the highest scores related to Standard VII—Provider Participation (Selection) and Program Integrity, which reached 91 percent average compliance. HSAG found the following common strengths among the CHP+ health plans:

- Health plans described provider outreach efforts that were informed by network adequacy data and a variety of targeted engagement efforts to retain providers.
- Program integrity departments maintained detailed policies, procedures, and work plans that demonstrated a depth of understanding related to federal and State requirements.
- Compliance officers often implemented a multi-tiered compliance committee system in order to tap into line-staff, management level, and senior leadership insights.

Statewide Conclusions and Recommendations Related to Compliance With Regulations

Three standards fell below 80 percent compliance within the previous three-year review cycle: Standard I—Coverage and Authorization of Services, Standard VI—Grievance and Appeal Systems, and Standard IX—Subcontractual Relationships and Delegation. The lowest scoring standard, Standard I—Coverage and Authorization of Services, reached only 78 percent compliance and the associated denial record reviews averaged 75 percent compliance during the FY 2019–2020 reviews.

During the FY 2020–2021 review period, the lowest scoring standards both reached only an average of 79 percent compliance (Standard VI—Grievance and Appeal Systems and Standard IX—Subcontractual Relationships and Delegation). HSAG found the following most common among the CHP+ health plans:

- Compliance scores across health plans ranged from 50 to 97 percent compliance.
- Grievance and appeal required actions included a variety of findings (i.e., timelines, member rights, and reading level) that needed to be updated within the member handbook, provider manual, and policies and procedures.
- HSAG recommended that health plans engage in periodic review of regulations to ensure policies and procedures are current, and ensure that updates are carried forward to desktop procedures and training materials.
- HSAG recommended ongoing efforts for appeal and grievance staff members to engage in a process to ensure member acknowledgement and resolution letters are written in member-friendly language.

- Compliance scores ranged from 50 to 100 percent compliance.
- Notably, the subcontract standard only includes four requirements, resulting in highly skewed scores if one sample contract did not contain required federal language. Most commonly, CHP+ health plans failed to include the required provisions that the State, CMS, HHS-OIG, Comptroller General, or other designees have the right to audit, evaluate, and inspect books, records, or premises as deemed necessary by the applicable agency. The contracts also required retention of records for only six years, which would not be sufficient to allow for agency audits through 10 years following the final date of the contract or agreement.
- HSAG recommended updates to template contracts as well as amendments to update existing delegation agreements.

Validation of Network Adequacy

Statewide Results

During FY 2020–2021, HSAG worked with the Department to update the quarterly network adequacy reporting materials and developed and deployed the NAV Dashboards. In preparation for the health plans' FY 2020–2021 Quarter 2 network adequacy data submissions, HSAG produced and distributed health plan-specific geoaccess compliance report templates to reduce preventable data submission errors and minimize the need for data resubmissions from the health plans.

Each quarter, HSAG validated the health plans' self-reported compliance with minimum time and distance network requirements and provided the Department with the validation results in NAV Dashboards and health plan-specific Results Briefs.

The data-related findings in this report align with HSAG's validation of the health plans' FY 2020–2021 Quarter 2 network adequacy reports, representing the measurement period reflecting the health plans' networks from October 1, 2020, through December 31, 2020.

Health plans may have alternate methods of ensuring members' access to care (e.g., the use of telehealth).

For a health plan to be compliant with the FY 2020–2021 minimum network requirements, the health plan is required to ensure that its provider network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level). For example, all members residing in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two family practitioners. However, if members reside in counties outside their health plan's contracted geographic area, the Department does not necessarily require the health plan to meet the minimum time and distance network requirements for those members. Additionally, the health plan may have alternate methods of ensuring access to care for its enrolled members, regardless of a member's county of residence (e.g., the use of telehealth).

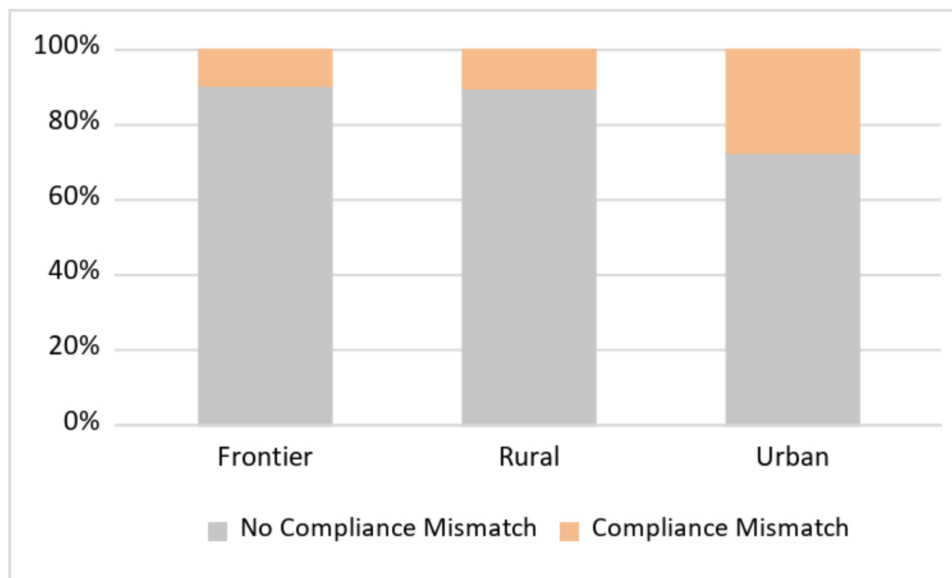
CHP+ Managed Care Organizations

This section summarizes the FY 2020–2021 NAV findings specific to the five CHP+ MCOs.

Compliance Match

Figure 4-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the health plans' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the health plans' quarterly geoaccess compliance results) among all CHP+ MCOs by urbanicity.

Figure 4-1—Aggregate CHP+ MCO Geoaccess Compliance Validation Results for FY 2020–2021 Quarter 2 by Urbanicity

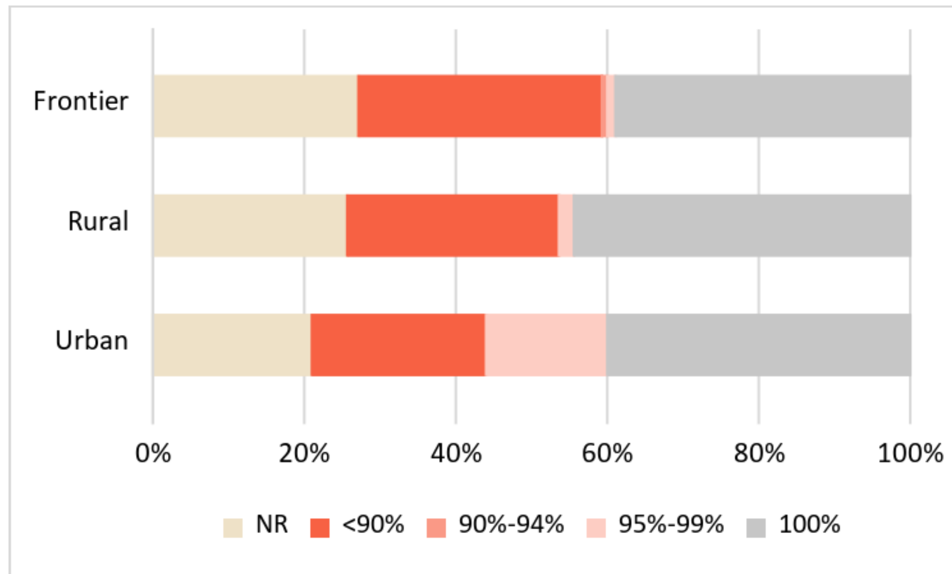


As shown in Figure 4-1, HSAG agreed with 90.6 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 89.8 percent of reported results for rural counties, and 72.6 percent of reported results for urban counties. HSAG disagreed with 9.4 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 10.2 percent of reported results for rural counties, and 27.4 percent of reported results for urban counties.

Access Level Assessment

Figure 4-2 displays the percentage of minimum time and distance physical health primary care network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with access within the minimum network requirement by urbanicity for FY 2020–2021 Quarter 2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance primary care network requirements for the selected counties, due to the limited number of adult CHP+ members.

Figure 4-2—Percentage of Aggregate CHP+ MCO Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance physical health primary care requirements include pediatric, adult, and family PCPs, as well as practitioners specializing in obstetrics and/or gynecology (OB/GYN). CHP+ MCOs are required to ensure that all members have two PCPs from each specified network type available within the specified network requirements. Since the CHP+ MCOs are contracted to cover different Colorado counties, each combination of a minimum time and distance requirement and county is measured separately.

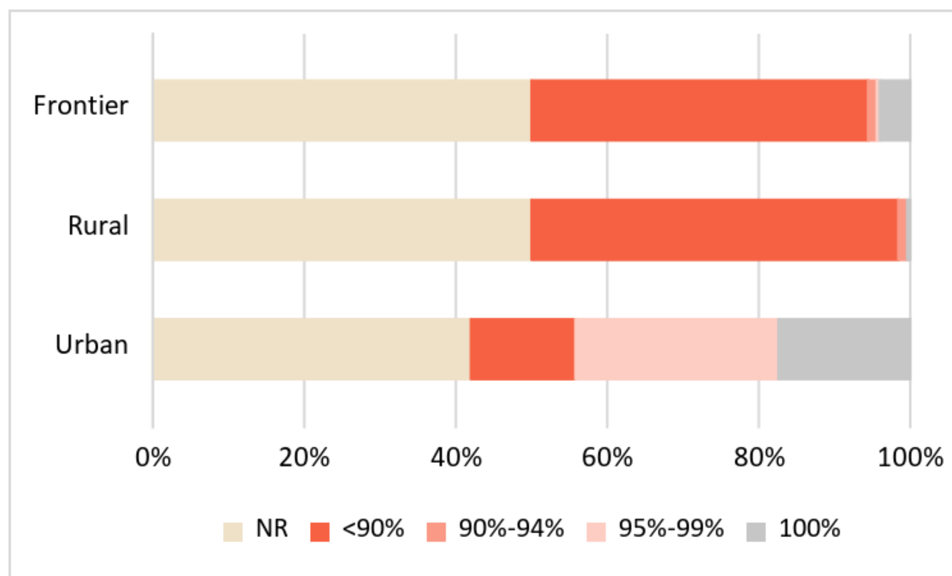
Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more providers in a given network category. As such, Figure 4-2 summarizes the number of physical health primary care results (i.e., minimum network time and distance requirement and county combinations) in which all members had access within the minimum network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 4-2 reflects a total of 280 physical health primary care results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in frontier counties. Of those 280 results, 38.9 percent (n=109) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 1.8 percent (n=5) of the results have 99 to 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 99 to 90 percent access level) and 32.1 percent (n=90) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level). As expected, due to the limited number of adult CHP+ MCO members, 27.1 percent (n=76) of the results have no CHP+ MCO members within the appropriate age range for the primary care requirements residing in the contracted frontier counties.

- The middle bar in Figure 4-2 reflects a total of 304 physical health primary care results, summarizing the percentage of members within each minimum network requirement and rural Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in rural counties. Of those 304 CHP+ MCO rural results, 44.4 percent (n=135) have 100 percent access level, 2.0 percent (n=6) of the results have 99 to 90 percent access level, and 28.0 percent (n=85) of the results have less than 90 percent access level. As expected, 25.7 percent (n=78) of the results have no CHP+ MCO members within the appropriate age range for the primary care network requirements residing in the contracted rural counties.
- The bottom bar in Figure 4-2 reflects a total of 200 physical health primary care results, summarizing the percentage of members within each minimum network requirement and urban Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in urban counties. Of those 200 CHP+ MCO urban results, 40.0 percent (n=80) have 100 percent access level, 16.0 percent (n=32) of the results have 99 to 90 percent access level, and 23.0 percent (n=46) of the results have less than 90 percent access level. As expected, 21.0 percent (n=42) of the results have no CHP+ MCO members within the appropriate age range for the primary care requirements residing in the contracted urban counties.

Figure 4-3 displays the percentage of minimum time and distance physical health specialist network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with access within the minimum network requirement by urbanicity for FY 2020–2021 Quarter 2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance physical health specialist network requirements for the selected counties, due to the limited number of adult CHP+ members.

Figure 4-3—Percentage of Aggregate CHP+ MCO Physical Health Specialist Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



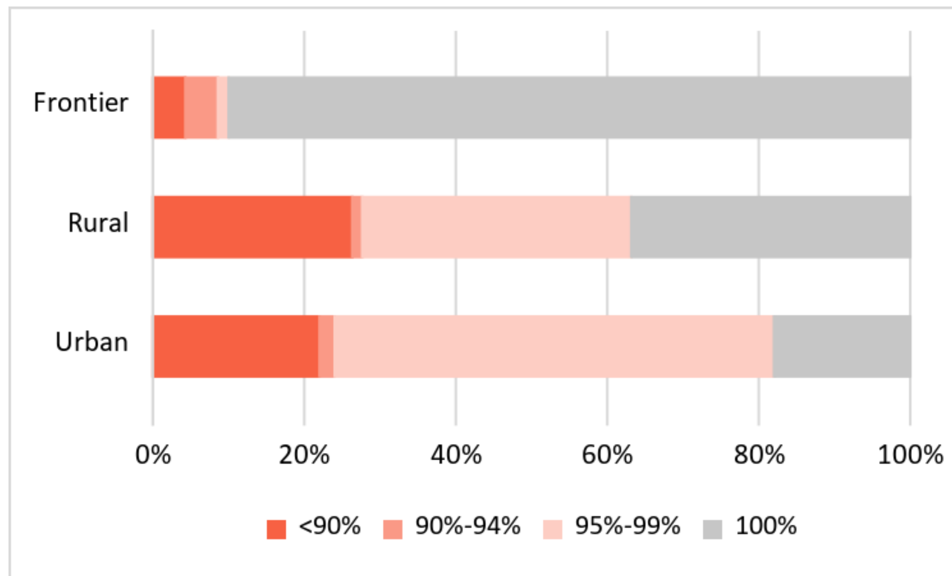
Minimum time and distance physical health specialist requirements include practitioners such as cardiologists, endocrinologists, and gastroenterologists, and CHP+ MCOs are required to ensure that all members have two physical health specialist practitioners from each specified network type available within the specified minimum network requirement.

Two or more practitioners in a given network category may not be located within the CHP+ MCOs' minimum network requirements for all members. As such, Figure 4-3 summarizes the number of physical health specialist results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the minimum network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 4-3 reflects a total of 700 physical health specialist results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members who had access within each minimum network requirement and frontier Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in frontier counties. Of those 700 results, 4.0 percent (n=28) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 1.6 percent (n=11) of the results have 90 to 99 percent of members that reside within frontier counties that met the minimum network requirements (i.e., 90 to 99 percent access level), and 44.4 percent (n=311) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level). As expected, due to the limited number of adult CHP+ MCO members, 50.0 percent (n=350) of the results have no CHP+ MCO members within the appropriate age range for the physical health specialist requirements residing in the contracted frontier counties.
- The middle bar in Figure 4-3 reflects a total of 760 physical health specialist results, summarizing the percentage of members within each minimum network requirement and rural Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in rural counties. Of those 760 CHP+ MCO rural results, 0.4 percent (n=3) have 100 percent access level, 1.2 percent (n=9) of the results have 90 to 99 percent access level, and 48.4 percent (n=368) of the results have less than 90 percent access level. As expected, 50.0 percent (n=380) of the results have no CHP+ MCO members within the appropriate age range for the physical health specialist requirement residing in the contracted rural counties.
- The bottom bar in Figure 4-3 reflects a total of 500 physical health specialist results, summarizing the percentage of members within each minimum network requirement and urban Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in urban counties. Of those 500 CHP+ MCO urban results, 17.4 percent (n=87) have 100 percent access level, 26.8 percent (n=134) of the results have 90 to 99 percent access level, and 13.8 percent (n=69) of the results have less than 90 percent access level. As expected, 42.0 percent (n=210) of the results have no CHP+ MCO members within the appropriate age range for the physical health specialist requirements residing in the contracted urban counties.

Figure 4-4 displays the percent of physical health entity requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with residential addresses within the minimum network requirements by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-4—Percentage of Aggregate CHP+ MCO Physical Health Entity Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance physical health entity requirements include acute care hospitals and pharmacies. CHP+ MCOs are required to ensure that all members have two physical health entities from each specified network type available within the specified time and distance requirement.

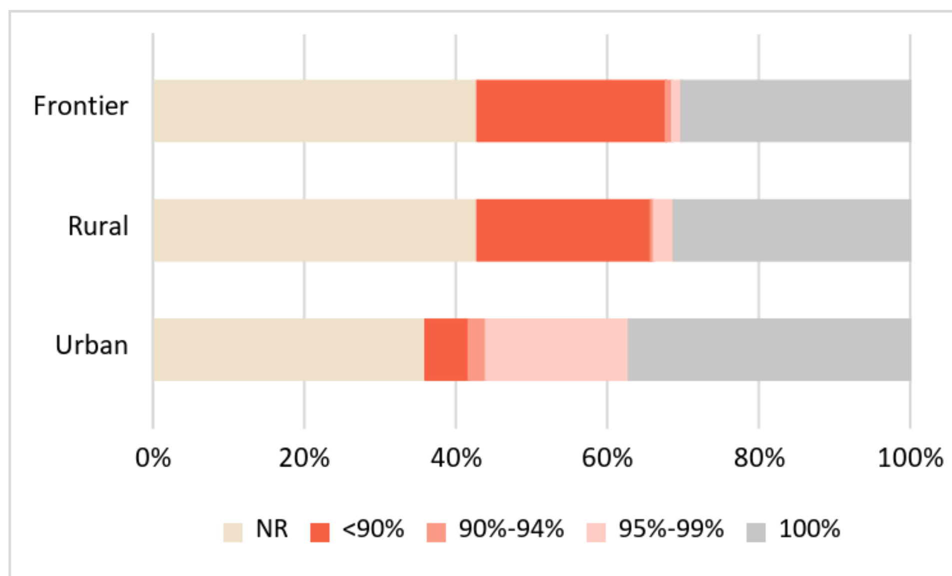
Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more entities in a given network category. As such, Figure 4-4 summarizes the number of physical health entity results (i.e., minimum time and distance network requirement and county combinations) in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

- The top bar in Figure 4-4 reflects a total of 70 physical health entity results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in frontier counties. Of those 70 results, 90.0 percent (n=63) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 5.7 percent (n=4) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 4.3 percent (n=3) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).

- The middle bar in Figure 4-4 reflects a total of 76 physical health entity results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in rural counties. Of those 76 CHP+ MCO rural results, 36.8 percent (n=28) have 100 percent access level, 36.8 percent (n=28) of the results have 90 to 99 percent access level, and 26.3 percent (n=20) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-4 reflects a total of 50 physical health entity results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in urban counties. Of those 50 CHP+ MCO urban results, 18.0 percent (n=9) have 100 percent access level, 60.0 percent (n=30) of the results have 90 to 99 percent access level, and 22.0 percent (n=11) of the results have less than 90 percent access level.

Figure 4-5 displays the percentage of minimum time and distance behavioral health requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of CHP+ MCO members with access within the requirement by urbanicity for FY 2020–2021 Quarter 2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance behavioral health network requirements for the selected counties, due to the limited number of adult CHP+ members.

Figure 4-5—Percentage of Aggregate CHP+ MCO Behavioral Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance behavioral health requirements include pediatric and adult psychiatrists and other psychiatric prescribers and substance use disorder (SUD) treatment practitioners and entities, as well as psychiatric hospitals or psychiatric units in acute care hospitals. CHP+ MCOs are required to

ensure that all members have two behavioral health practitioners or practice sites from each specified network type available within the specified time and distance requirement.

Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more providers in a given network category. As such, Figure 4-5 summarizes the number of behavioral health results (i.e., minimum time and distance network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- The top bar in Figure 4-5 reflects a total of 245 behavioral health results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in frontier counties. Of those 245 results, 30.2 percent (n=74) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 2.0 percent (n=5) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 24.9 percent (n=61) of the results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level). As expected, due to the limited number of adult CHP+ MCO members, 42.9 percent (n=105) of the results have no CHP+ MCO members within the appropriate age range for the behavioral health requirements residing in the contracted frontier counties.
- The middle bar in Figure 4-5 reflects a total of 266 behavioral health results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in rural counties. Of those 266 CHP+ MCO rural results, 31.2 percent (n=83) have 100 percent access level, 3.0 percent (n=8) of the results have 90 to 99 percent access level, and 22.9 percent (n=61) of the results have less than 90 percent access level. As expected, 42.9 percent (n=114) of the results have no CHP+ MCO members within the appropriate age range for the behavioral health requirements residing in the contracted rural counties.
- The bottom bar in Figure 4-5 reflects a total of 175 behavioral health results, summarizing the percentage of members within each minimum network requirement and urban Colorado county applicable to the combined CHP+ MCOs contracted to serve members residing in urban counties. Of those 175 CHP+ MCO urban results, 37.1 percent (n=65) have 100 percent access level, 21.1 percent (n=37) of the results have 90 to 99 percent access level, and 5.7 percent (n=10) of the results have less than 90 percent access level. As expected, 36.0 percent (n=63) of the results have no CHP+ MCO members within the appropriate age range for the behavioral health requirements residing in the contracted urban counties.

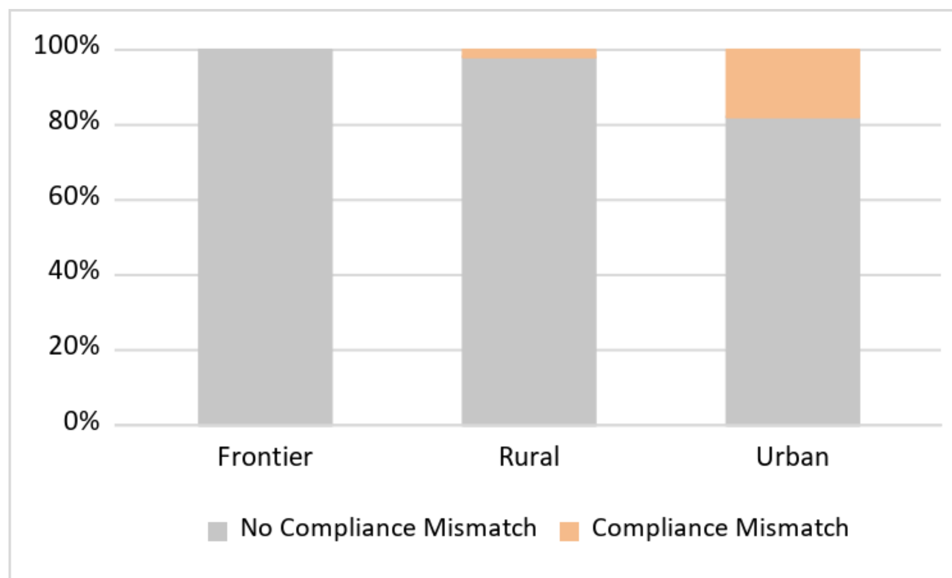
Dental Prepaid Ambulatory Health Plan

This section summarizes the FY 2020–2021 NAV findings specific to the PAHP.

Compliance Match

Figure 4-6 displays the rate of compliance mismatch (i.e., HSAG did not agree with the PAHP's quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the PAHP's quarterly geoaccess compliance results) by urbanicity.

Figure 4-6—Aggregate PAHP Geoaccess Compliance Validation Results for FY 2020–2021 Quarter 2 by Urbanicity

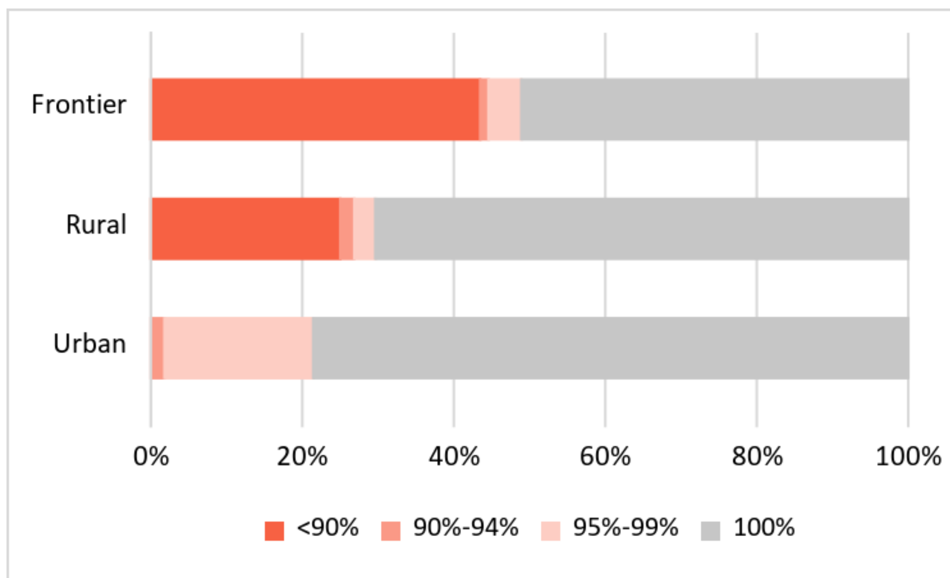


As shown in Figure 4-6, HSAG agreed with 100 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 98.1 percent of reported results for rural counties, and 82.1 percent of reported results for urban counties. HSAG disagreed with 1.9 percent of the PAHPs' reported quarterly geoaccess compliance results for rural counties and 17.9 percent of reported results for urban counties.

Access Level Assessment

Figure 4-7 displays the percentage of minimum time and distance dental network requirements having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of PAHP members with access in the network requirement by urbanicity for FY 2020–2021 Quarter 2.

Figure 4-7—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2020



Minimum time and distance dental requirements pertain to general and pediatric dentists, as well as practitioners specializing as oral surgery or orthodontics. The PAHP is required to ensure that all members have one dental practitioner from each specified network type available within the specified time and distance requirement.

Not all members may reside within the PAHP's contractual minimum network requirements for one practitioner in a given network category. As such, Figure 4-7 summarizes the number of dental results (i.e., minimum time and distance network and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- The first bar in Figure 4-7 reflects a total of 92 dental results (i.e., minimum time and distance network requirement and county combinations), summarizing the percentage of members within each network requirement and frontier Colorado county applicable to the PAHP contracted to serve members residing in frontier counties. Of those 92 results, 51.1 percent (n=47) have 100 percent of PAHP members with residential addresses in frontier counties that had access within the minimum network requirements (i.e., 100 percent access level). An additional 5.4 percent (n=5) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level) and 43.5 percent (n=40) of the

results have less than 90 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., less than 90 percent access level).

- The second bar in Figure 4-7 reflects a total of 108 dental results, summarizing the percentage of members within each network requirement and rural Colorado county applicable to the PAHP contracted to serve members residing in rural counties. Of those 108 PAHP rural results, 70.4 percent (n=76) have 100 percent access level, 4.6 percent (n=5) of the results have 90 to 99 percent access level, and 25.0 percent (n=27) of the results have less than 90 percent access level.
- The third bar in Figure 4-7 reflects a total of 56 dental results, summarizing the percentage of members within each network requirement and urban Colorado county applicable to the PAHP contracted to serve members residing in urban counties. Of those 56 PAHP urban results, 78.6 percent (n=44) have 100 percent access level and 21.4 percent (n=12) of the results have 90 to 99 percent access level.

Statewide Conclusions and Recommendations

The Department used the FY 2020–2021 NAV to expand prior years' NAV activities, requesting that HSAG begin quarterly validation of the health plans' self-reported compliance with minimum network requirements, and move the display of NAV results into interactive, web-based dashboards to facilitate the Department's comparison of quarterly NAV results across and within health plans, network requirements, and counties. The health plans' consistent use of Department-approved quarterly network adequacy reporting materials within a single fiscal year allowed the Department to begin evaluating the health plans' network data for consistent, complete reporting over time. The health plans' FY 2020–2021 Quarter 2 network adequacy reports reflected the first quarterly NAV cycle in which none of the health plans were required to resubmit their member or network data files, indicating an improvement in the health plans' ability to submit quarterly network adequacy reports and accompanying data files in alignment with the Department-approved reporting materials.

When reviewing the health plans' geoaccess compliance results and HSAG's corresponding NAV results, however, it is important to note that the health plans' contractual network requirements require the health plan to ensure that 100 percent of its applicable members have network access within the minimum time or distance requirements (i.e., 100 percent access level). If members reside in counties outside their health plan's contracted geographic area, the Department does not necessarily require the health plan to meet the minimum time and distance network requirements for those members.

As a result, a health plan's failure to meet the minimum network time or distance requirements may reflect different factors, including a lack of contracted healthcare practitioners; a nuance of the health plan's mapping between its network data and the Department's reporting templates; or a limited number of members whose travel time or distance to a practitioner, practice site, or entity is greater than the defined time and distance requirement. If a health plan had fewer than 100 percent of its members within the minimum network requirements, the health plan may have also made accommodations for members with special circumstances.

Table 4-5 displays the rate of compliance matches (i.e., HSAG agreed with the health plans' quarterly geoaccess compliance results), by health plan type and urbanicity. For example, HSAG agreed with 90.6 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties.

Table 4-5—Aggregate Percentage of Geoaccess Compliance Matches for FY 2020–2021 Quarter 2 by Health Plan Type and Urbanicity

Health Plan Type	Percentage of Matching Geoaccess Compliance Results in Frontier Counties	Percentage of Matching Geoaccess Compliance Results in Rural Counties	Percentage of Matching Geoaccess Compliance Results in Urban Counties
CHP+ MCOs	90.6%	89.8%	72.6%
PAHP	100%	98.1%	82.1%

To continue enhancement of its network adequacy oversight, the Department directed HSAG to modify the FY 2020–2021 quarterly network adequacy reporting materials to align with network needs that support ongoing service enhancements and network adequacy oversight. For example, HSAG and the Department updated the Network Crosswalk document to incorporate information on *interChange* practitioner, practice site, and entity type and specialty definitions for network categories that align with the health plans' quarterly network requirements. Due to the nature of the *interChange* data, direct alignment does not exist between *interChange* practitioner definitions and the health plans' quarterly network adequacy reporting materials for all network categories. However, harmonizing the *interChange* and health plan network category descriptions where possible will facilitate network data QI using comparisons between the health plans' network data and the *interChange* network data.

Due to the nature of the study methodology and data sources, key analytic considerations applicable to the FY 2020–2021 NAV results briefly include the following:

- Network categories in the FY 2020–2021 NAV results were limited to those reflected in the health plans' minimum network requirements, and HSAG validated only the health plans' self-reported time and distance geoaccess compliance results. Time or distance results represent a high-level measurement of the geographic distribution of network locations relative to members' place of residence, as reported by the health plan. Such raw, comparative statistics do not account for the individual status of a practitioner's panel (i.e., accepting or not accepting new patients) at a specific location or how active the network location is in the CHP+ program.
- Network data submitted to HSAG by the health plans may not reflect the current status of the health plans' networks or changes implemented since the January 2021 data submission deadline, and data may have included practitioners, practice sites, and entities that support additional healthcare services covered by Colorado's CHP+ program.
- NAV findings depend on the quality of member and network data supplied by the health plans, including the health plans' application of the Department-approved Network Crosswalk to attribute records to network categories. It was beyond the FY 2020–2021 NAV scope to evaluate the accuracy of the health plans' network data against an external network requirement (e.g., using

telephone survey calls to verify the accuracy of network locations, contact information, or services offered).

Promising Practices and Opportunities for Improvement

Based on the FY 2020–2021 NAV process and analytic results, HSAG offers the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the health plans' compliance with network adequacy contract requirements and the provision of high-quality network data:

- **Enhance Network Data Quality**: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. Each health plan will be expected to use the detailed data quality results to improve the quality of their quarterly member and network data submissions to the Department.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the health plans' networks through the development and implementation of standardized quarterly network adequacy reporting materials. The Department has directed its EQRO to conduct the following activities during FY 2021–2022:
  - An evaluation of the existing process(es) by which the health plans are directed to request and receive exceptions to network requirements. If supported by the evaluation findings, the Department may consider standardizing the health plan exception request documentation and processes to ensure uniform review and documentation of the health plans' network exceptions.
  - An evaluation of the appropriateness of the minimum time and distance network requirements in the health plans' contracts with the Department. The evaluation may also consider the extent to which the health plans offer alternate service delivery mechanisms to ensure members' access to care when minimum time or distance requirements may not be appropriate based on the geography and/or network category. For example, the Department may consider the extent to which a health plan offers and ensures that members are able to use telehealth modalities to obtain behavioral health services when practitioners are not available in rural or frontier counties.
- **Expand Network Adequacy Evaluation**: To further assess network availability, the Department should review ways to evaluate the health plans' compliance with contract network requirements for access to care, including the following:
  - Future access to care evaluations may incorporate the health plans' encounter data to assess members' utilization of services and potential gaps in access to care resulting from limited network availability.
  - The Department may also consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data available to the health plans' members and align with the network data supplied to the Department for the quarterly network adequacy compliance reporting.
  - In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department may choose to review member satisfaction survey results and

grievance and appeals data to identify results and complaints related to health plan members' access to care. Survey results and grievance and appeals data may then be used to evaluate the degree to which members are satisfied with the care they have received and the extent to which unsatisfactory care may be related to a health plan's limited network availability.

CAHPS Surveys

Statewide Results for CAHPS

The statewide aggregate rate results presented in Table 4-6 are derived from the combined results of the five CHP+ MCOs. Table 4-6 shows the FY 2020–2021 MCO-level and statewide aggregate rate results for each CAHPS measure.[4-1]

Table 4-6—Statewide Comparison of Top-Box Scores

Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Aggregate Rate
Getting Needed Care	79.2%	86.8%	81.8%+	78.0%	83.4%	80.1%
Getting Care Quickly	85.9%	87.3%	87.1%+	88.0%+	89.0%	86.6%
How Well Doctors Communicate	92.9% ↓	96.6%	97.8%+ ↑	95.1%	97.0%	94.1%
Customer Service	87.4%+	88.8%	87.3%+	83.0%+	89.1%+	87.2%
Rating of Health Plan	66.5%	70.0%	63.8%	66.0%	70.2%	67.0%
Rating of All Health Care	73.1%	77.5% ↑	58.3%+ ↓	70.6%	73.5%	72.7%
Rating of Personal Doctor	78.2%	81.5% ↑	64.2% ↓	77.7%	74.1%	77.4%
Rating of Specialist Seen Most Often	68.2%+	70.2%+	69.4%+	80.0%+	73.2%+	69.6%

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.

Statewide aggregate rate scores are added for reference.

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

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

[4-1] 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.

Statewide Conclusions and Recommendations for CAHPS

The following results show the differences in the quality of care and services the CHP+ MCOs received compared to the statewide aggregate rate. Three of the five MCOs showed statistically significant differences: COA, DHMP, and FHP. Three of the eight measures showed statistically significant results: *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

- COA scored higher than the statewide aggregate rate for three measures: *Customer Service*, *Rating of All Health Care*, and *Rating of Personal Doctor*. COA scored statistically significantly lower than the statewide aggregate rate for one measure, *How Well Doctors Communicate*.
- DHMP scored statistically significantly higher than the statewide aggregate rate for two measures: *Rating of All Health Care* and *Rating of Personal Doctor*. DHMP did not score lower than the statewide aggregate rate for any measure.
- FHP scored higher than the statewide aggregate rate for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. FHP scored statistically significantly higher than the statewide aggregate rate for one measure, *How Well Doctors Communicate*. FHP scored lower than the statewide aggregate rate for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. FHP scored statistically significantly lower than the statewide aggregate rate for two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.
- Kaiser scored higher than the statewide aggregate rate for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Kaiser scored lower than the statewide aggregate rate for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Health Plan*, and *Rating of All Health Care*.
- RMHP scored higher than the statewide aggregate rate for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. RMHP scored lower than the statewide aggregate rate for one measure, *Rating of Personal Doctor*.

HSAG recommends the Department explore reasons specific measure rates were higher or lower than rates from previous years and determine if any best practices can be shared or interventions or actions duplicated to improve measure rates. In addition, HSAG recommends the Department work with the MCOs to develop initiatives to improve processes or conduct studies to further evaluate the key drivers that may impact members' perceptions of the quality of care of their children's personal doctors, including how well they communicate, and their children's overall healthcare. For example, if a large portion of members receive care coordination, then the MCOs can conduct an assessment of utilization review turnaround times or of care coordination processes. In addition, the MCOs may want to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters.

For additional information about CHP+ CAHPS activities and results for FY 2020–2021, refer to the aggregate CHP+ CAHPS report on the Department's website (https://hcpf.colorado.gov/client-satisfaction-surveys-cahps).

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

Colorado Access

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated Module 3 for the COA *Well-Child Visits for Members 10–14 Years of Age* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for COA to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report for the PIP including interventions tested, successes, and lessons learned. Table 5-1 summarizes COA's PIP close-out report.

Table 5-1—COA FY 2019–2020 *Well-Child Visits for Members 10–14 Years of Age* PIP Close-Out Summary

Interventions	In-person provider training on best practices for billing for well visits provided collaboratively by the EMR and data analytics teams.
Successes	Established data sharing and a monthly reporting process with provider partner.
Lessons Learned	The importance of clearly communicating PIP requirements/expectations—interventions and data collection—to the provider partner and obtaining buy-in/commitment from the provider partner up front.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, COA reported that it implemented the following interventions:

- For the *Well-Child Visits in the First 30 Months of Life* measure, COA's care management programs encouraged well-child and adolescent well care by assisting the member/guardian with locating and scheduling an appointment with a PCP. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Check program reminded parents/guardians of CHP+ HMO members to utilize their covered well-child visit. Additionally, the Community Health Provider Alliance (CHPA) initiated a joint work plan to increase the number and percentage of COA CHP+ members who receive well-child checks from their attributed CHPA clinic.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, COA's care management programs encouraged establishment of a PCP to complete well-child visits, age-appropriate screenings, and immunizations. Care managers provided member/guardian with education, appropriate resources if they had any questions or concerns surrounding nutrition and/or physical activity, and encouraged the member/guardian to follow up with their provider to discuss the concerns and further options.
- For the *Chlamydia Screening in Women* measure, COA's care management programs encouraged adolescent well-care and age-appropriate screenings by assisting the member/guardian with locating and scheduling an appointment with a PCP.
- For the *Follow-Up Care for Children Prescribed ADHD Medication* measure, COA's Behavioral Health Care Management program assisted members prescribed medication(s) that involve more frequent provider monitoring by ensuring follow-up appointments are scheduled and attended, and questions regarding medication management for ADHD medications or antipsychotics are answered by the prescriber or pharmacist.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed two standards: Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. For Standard I—Coverage and Authorization of Services, COA was required to complete the following actions:

- Ensure members receive written notification of any decision to deny or partially deny a claim, and that the NABD is easy for the member to understand and includes all required content (three required actions).
- Ensure the NABD is mailed within required time frames and any exceptions for the NABD mailing time frame are accurately captured in policy (two required actions).
- Correct the UM policy to include accurate and detailed procedures related to poststabilization, such as determining financial responsibility for payment of poststabilization services that were not pre-approved (two required actions).

COA submitted its initial CAP proposal in May 2020. Following Department approval, COA successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

To follow up on recommendations related to FY 2019–2020 CAHPS, COA reported engaging in the following QI initiatives:

- Continued to run internal rating measures examining customer service ratings by an external organization that providers timely feedback to customer service managers who can address ratings of associates and remedy issues immediately.
- Educated providers and members in the CHP+ quarterly newsletter, as well as customer service and care management teams regarding the purpose of the CAHPS survey for the first time to increase response rates and for more actionable feedback.
- The quality department presented to the Member Advisory Committee to share results and obtain feedback regarding the *Customer Service* and *Rating of Specialist Seen Most Often* measures.
- Administered a third iteration of the Customer Satisfaction Survey for continued and more up-to-date identification of improvement opportunities.
- Introduced new collaborative efforts within customer service, care management, and provider relations to develop processes to increase information sharing for targeted secret shopper calls to 1) better understand member experience and 2) initiate interventions to improve experience.

Denver Health Medical Plan, Inc.

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated Module 3 for the DHMP *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for DHMP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-2 summarizes DHMP's PIP close-out report.

Table 5-2—DHMP FY 2019–2020 *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP Close-Out Summary

Interventions	Partnering with SBHCs to outreach, schedule, and deliver well-care visits for adolescent members consented to receive care at SBHCs.
Successes	• Established partnership with SBHC leadership. • Developed communication system with community partners. • Developed EMR data extraction process to support automated text messages. • Improved adolescent well-care rates during the project.
Lessons Learned	• Partnership with SBHCs was critical to the success of the project and suggests continued partnership can lead to further improvement in outcomes for the adolescent member population. • Technology development to support the intervention took longer than expected; going forward, additional time will be allowed for interventions relying on further development of technology.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, DHMP reported that it implemented the following interventions:

- DHMP maintained and expanded active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in prevention, screening, and annual visits. Work groups were established in the following areas: pediatric care, obesity, asthma, cancer screening, integrated behavioral health, immunizations, and the ambulatory care quality improvement committee (QIC).
- Partnered in collaborative work process with QI Director of ACS and ACS QI staff to build joint QI interventions, including shared data analytics.
- Continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS scores.
- Continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores.
- Increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- 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.
- Continued pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization.
- Maintained reporting of quality of care concerns (QOCCs), and facilitated process improvements as identified during the QOCC review process.
- Developed clinical practice guidelines to cover the lifespan from infancy to geriatric.
- Streamlined clinical and preventive guidelines review and updating process.
- Increased physician involvement in the development of clinical guidelines.
- Continued development, review, and revision of policies and procedures annually through electronic tracking of the organization's transition to an updated system, PolicyStat.
- Maintained physician involvement within the quality management committee (QMC) structure.
- For well-child visits, EPSDT, and immunizations, DHMP implemented the following:
  - Increased compliance with EPSDT-related standards, with additional provider and member communication on services, provider communication about EPSDT requirements, and edits to related policy and procedures. Ongoing efforts continue for wraparound services outside of the health plan, and for tracking of referrals for services outside the health plan, by network providers. Improved the number of EPSDT services tracked at ACS, available by clinic and provider.
  - Healthy Hero Birthday Cards: In an effort to reach members ages 19 and under, DHMP QI and marketing sends annual birthday cards monthly to children ages 2 through 19 that provide a checklist with information on healthy eating, development, vaccines, and physical activity. 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. The card for members also included the contact information for Healthy Communities and how to schedule an appointment through Healthy Communities.

- SBHCs: DHMP members have access to 18 SBHCs within Denver Public elementary, middle, and high schools. SBHCs provide a variety of services such as well-child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral healthcare services. Denver Health and Hospital Authority (DHHA) and DHMP continue to encourage eligible members to access care through the DHMP network of SBHCs. This information is sent directly to member households in newsletters and is also available on the DHMP member website. In addition, the DHHA appointment center utilizes a process that alerts schedulers of an SBHC-enrolled student, which will prompt them to schedule the child at an SBHC for their clinic needs. For the DHMP adolescent Medicaid population, collaboration with the Denver Public Schools' (DPS') SBHCs to identify and see members for well-child visits during school hours has been highly successful in the past. As students return to in-person learning in the 2021–2022 school year, DHMP will be looking to restart collaboration with the SBHC team leads to get members who are consented to be seen at an SBHC the care they need in a timely manner.

- For asthma, the Asthma Work Group (AWG) and registered nurse (RN) line utilizes a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. Members are also informed about the need to make an asthma assessment appointment with their PCP if they have refilled their rescue medication without refilling the appropriate number of controller medications. The DHMP pharmacy team has directed more focus on the need to consistently refill asthma controller medications and began utilizing a pharmacy vendor tracking system in FY 2020–2021 to streamline this process. In Q4 of FY 2020–2021, the DHMP pharmacy team began working with DHHA ACS to provide lists of non-compliant members to their respective PCPs for intervention. This effort will continue into FY 2021–2022.
- For Access to Care measures, DHMP did the following:
  - Denver Health continues to operate 18 SBHCs that provide healthcare in an easy and convenient setting to all health plan members who attend DPS.
  - Several strategies were developed to reduce the wait list, including an improved new patient workflow for the Appointment Center, the hiring and placement of providers in key locations, collaboration between the Appointment Center and clinics to fill open appointment slots, and adjusted provider panel sizes. Saturday morning hours for primary care at three locations have continued at the Montbello Health Center, Denver Health main campus, and at the Westside Family Health Center on Federal Boulevard.
  - In summer of 2021, the new DHHA Outpatient Medical Center (OMC) formally opened. The OMC is a 293,000 square-foot, state-of-the-art facility located just across from the main hospital that will consolidate 20 specialty clinics, procedural areas, day surgery, and ancillary services into one convenient location, providing increased space and access in specialty care areas such as cardiology, orthopedics, outpatient behavioral health, and dental services. The OMC frees space on the main campus to continue growth in pediatric services and allow DHMP to increase the number of inpatient psychiatric beds. The modern facilities and state-of-the-art technology will

increase capacity and allow DHMP to coordinate services more effectively, enabling providers to deliver better care for members.

- New DHMP members are sent a welcome packet including their ID card and Quick Reference Guide. DHMP also provides orientation videos in English and Spanish on the website for members. These videos inform DHMP members about their benefits and provide information on how the plan works. DHMP staff members strive for excellence in care and service for all members in accordance with contract requirements.
- DHMP maintains a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine is capable of discussing the member's symptoms and concerns, assisting the member in understanding the urgency of their need and can assist with deciding the best course of action based on the urgency to see their PCP or going to the urgent care or emergency department. Additionally, the NurseLine nurses can write prescriptions for some illnesses and can also schedule a Dispatch Health visit.
- In early 2019 DHMP began contracting with Dispatch Health to support the membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. With the COVID-19 pandemic impacting hospital care, DHMP expanded the use of Dispatch Health to include skilled nursing facility (SNF) at home, hospital at home, and bridging services to assist in early discharges.
- Throughout the COVID-19 public health emergency, the ability of members to message their PCP and care team through MyChart has shown its value. MyChart is a user-friendly application/website with multiple capabilities available to members to enhance and support their experience. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, review lab results, communicate directly with providers, and serves as a centralized location for tracking their health outcomes and programs. It was used this year to send mass messages about the availability of the COVID-19 vaccine as requirements changed rapidly. During the COVID-19 response, MyChart also became a telehealth urgent care option for members and was the main mechanism utilized in scheduling COVID-19 vaccinations.
- Due to COVID-19, many services transitioned to providing telehealth options.
- DHMP expanded its PCP footprint by contracting with STRIDE Community Health Center. The partnership adds 15 additional clinic locations (three of which have pharmacies on-site) and expanded options for DHMP's members.
- DHMP was excited to announce in 2020 the grand opening of the Denver Health Sloan's Lake Primary Care Center, DHMP's 10th Community Health Center in the Denver metropolitan area. Providing the same leading services offered at other DHMP locations, the new center is easily accessible for patients in Denver's Sloan's Lake, West Colfax, and Villa Park neighborhoods and opens in partnership with the Denver Housing Association, which provides senior housing located above the clinic.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed two standards: Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG identified opportunities for improvement that resulted in the following required actions.

For Standard I—Coverage and Authorization of Services, DHMP was required to complete one required action:

- Correct medical necessity denial letters regarding dates, time frames, and information for continuation of benefits and SFHs.

For Standard II—Access and Availability, DHMP was required to complete two required actions:

- Develop mechanisms to track timely access for behavioral health, SUD, non-urgent symptomatic care, and follow-up care after inpatient hospitalization.
- Monitor providers to ensure compliance with timely access standards and use CAPs if the providers fail to comply.

DHMP submitted its initial CAP proposal in April 2020. Following Department approval, DHMP successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

To follow up on recommendations related to FY 2019–2020 CAHPS, DHMP reported engaging in the following QI initiatives:

- Improved communication with clinics about health plan QI initiatives, including education about health plan CAHPS scores.
- Increased member outreach through Acute Coronary Syndrome care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Implemented focused member outreach and care management to facilitate care transitions when acuity of need was identified.

- Developed and implemented enhanced patient education materials specific to chronic disease states and COVID-19 vaccination.
  - The DHHA system is working to provide greater appointment availability by expanding capacity, hours of operation, and specialty services.
  - DHHA is working to expand access to care across numerous clinics and specialties.
  - The COVID-19 state of emergency has helped launch a new way of providing care using telemedicine. All providers are working toward use of virtual technology, in particular a new telemedicine urgent care is now fully functional.
  - To improve communication options, established patients are able to message their PCP and care team and schedule primary care visits through Epic MyChart.
  - The DHHA appointment center triages calls to escalate care when medically necessary.
  - There is a 24-hour NurseLine that is available for members when the appointment center is closed and when members describe experiencing specific symptoms.
  - Organizationally, there is an increased focus on improving consistent access to care through a delivery network, which builds relationships that result in increased satisfaction with the healthcare system and better health outcomes for the population.
  - To have increased insight into members' access to care, DHMP implemented a provider open shopper process. The Health Plan Services (HPS) team contacts providers to request appointment availability for different types of services. This process allows DHMP to monitor the network's ability to have timely access to services.
    - Efforts continue to improve HPS. The HPS team provides real-time training for staff members regarding member services call QI. The HPS team lead reviews calls from every staff member and performs on the spot evaluation and training. The team lead regularly performs sample audits of calls for each call representative. All HPS phone audit report results are presented and discussed b-monthly at the DHMP QMC.
- Worked with the member services department to develop a work plan that outlines the processes to effectively track member satisfaction. Each call with a member services representative concludes with the question, "Have I provided the help or information you needed today?" This is recorded in DHMP's care management software. Monitoring is conducted to ensure that member services representatives are asking the question. When members answer "no" to the above question, member services representatives track the reasons the member cites for not getting the help or information they needed. Tracking these reasons will assist in identifying process improvement and staff training opportunities.
- To understand the full spectrum of members' needs, DHMP has been performing a health needs assessment (HNA) of all new members. DHMP engaged a vendor to outreach to members to perform an initial HNA. The HNA engages the member with a series of health (physical and behavioral) and social determinants of health questions to identify the member's concerns and needs. The results of the HNA are communicated to the care coordination team, who follows up with the member. Based on the individual's needs, the care coordinator provides general information and resources (including community-based organizations), referrals, connection to a medical home, and

general support. The HNA is mailed to all members and then is followed up with direct phone calls to the member.

- Modeling the Colorado Department of Health Care Policy & Financing's (HCPF's) risk stratification dashboard, DHMP has built a risk stratification tool that allows DHMP to monitor and analyze the member's health and needs. The tool allows DHMP to target specific conditions or issues (e.g., high number of emergency department visits) to outreach directly to members to provide education and resources.

Friday Health Plans of Colorado

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated Module 3 for the FHP *Well-Child Visits in the 6–14 Years of Life* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for FHP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-3 summarizes FHP's PIP close-out report.

Table 5-3—FHP FY 2019–2020 *Well-Child Visits in the 6–14 Years of Life* PIP Close-Out Summary

Interventions	Member outreach calls.
Successes	Improvement of child well visit rates during the project.
Lessons Learned	Identified the need for additional quality staff members to support improvement efforts and expanded staffing.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, FHP reported that it implemented the following interventions:

- Well-child exams for ages 10 to 14 years at San Luis Valley Health. This intervention was created in order to increase the number of members who receive their well-child visits between the ages of 10 and 14. FHP reviewed and filtered the data it had at hand, and were able to select a narrower focused group from the state-mandated topic. First, FHP narrowed it down to facilities and members who live within their geographical location since they are so rural and remote. FHP felt they would have the largest impact initially within the San Luis Valley as it would be easier to connect face-to-face with providers and reach out easier to the parents of FHP members. Once FHP decided where it was going to focus its efforts, it looked at the data to see which one of the three clinic systems in its area had the highest denominator and lowest numerator, and in which age group these members fell. FHP then selected a narrow focused group to children between the ages of 10 and 14 at San Luis Valley Health. In order to obtain the necessary information, FHP ran a couple of reports within its Xpress system. The first report included all members who met the enrollment criteria ages 0 to 18, their provider name and address, and line of business for CPT codes 99383 and 99384. This gave FHP denominators for the members who qualified for a well-child exam. FHP then ran another report with the same information, but from its claims section in Xpress, which then provided FHP with the information on who actually received the services included in CPT codes 99383 and 99384. Once FHP had the data in Microsoft Excel format, it was able to sort by line of business, age group, and provider. Once FHP had this information, it sorted out the data for the CHP+ line of business and selected a narrow focused group based on who had the largest denominator, but the smallest numerator. Once FHP analyzed the data, it selected members ages 10 to 14 who receive care at San Luis Valley Health.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed two standards: Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG identified opportunities for improvement that resulted in the following required actions.

For Standard I—Coverage and Authorization of Services, FHP was required to:

- Correct documents to include accurate time frames (72 hours) for making expedited authorization decisions and notifying the member.
- Ensure that its pharmacy benefit management (PBM) has accurate policies and procedures regarding the time frame for providing notice of authorization for covered outpatient drugs and complies with the requirement to provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information. In addition, develop or enhance FHP policies and procedures to address review and notification.

- Update NABD taglines informing the member of availability of the notice in alternative formats. FHP must also ensure that all information in the NABD is written in language easy for the member to understand.
- Update NABDs to include accurate appeal information and remove the description of reconsiderations.
- Enhance or develop operating procedures to ensure NABDs are mailed within required time frames.
- Develop policies and procedures for NABDs regarding reduction, suspension, or termination of a previously authorized service, or clarify within policies and procedures that FHP never denies previously authorized services.
- Enhance procedures for reviewing emergency claims and address the requirement to pay for emergency services if a representative of FHP instructed the member to seek emergency services.
- Develop policies or procedures to guide staff members regarding financial responsibility for poststabilization services (this action covers five related requirements).

For Standard II—Access and Availability, FHP was required to complete three required actions:

- Update or expand its standards for timely access to include emergency behavioral healthcare by phone and in person, outpatient follow-up appointments, and not placing members on waiting lists for initial routine behavioral health services. Additionally, FHP was required to expand the Scheduling Wait Time Log Audit to include monitoring of these additional standards for timely access or develop an alternative mechanism for doing so.
- Develop a written procedure that outlines the full process for monitoring timely access standards and addresses all elements of the requirement—e.g., mechanism for monitoring, frequency of monitoring, and taking corrective action.
- Develop and implement mechanisms to ensure staff members are provided cultural competency training programs regarding cultural factors affecting access to care or medical risks.

FHP submitted its initial CAP proposal in February 2020. Following Department approval, FHP successfully completed implementation of all planned interventions in November 2020.

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 continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

To follow up on recommendations related to FY 2019–2020 CAHPS, FHP reported engaging in the following QI initiatives:

- Hired new employees to assist with answering calls more quickly and not keep members waiting on hold for a long period of time.
- Customer service implemented a training manual (desk aide) to be able to be uniform in the way that questions or information is provided to members. Additionally, scripts are being created for consistent messaging.
- Implemented a first call resolution goal to be able to resolve an issue on the first call and not transfer the member's call.
- Set weekly goals to answer the phones and provide information or answers to members in a timely manner with no complaints. To give members the best service possible, an incentive has been set that allows the staff to leave one hour early when the goal of weekly calls with no complaints has been reached.
- Decreased authorizations to remove barriers.
- Conducts case management and may assist the members in locating specialists' or other providers' contact information for the members to set up an appointment.

Kaiser Permanente Colorado

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated Module 3 for the Kaiser *Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for Kaiser to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-4 summarizes Kaiser's PIP close-out report.

Table 5-4—Kaiser FY 2019–2020 *Improving CHP+ Adolescent Well-Visit Adherence for Members 15–18 Years of Age* PIP Close-Out Summary

Interventions	Real-time appointment scheduling during outreach calls.
Successes	Improvement of adolescent well-care rates during the project.
Lessons Learned	• Phone calls were successful while mailers were not successful at getting adolescent well visits scheduled. • Adding weekend and evening well-visit appointment options allowed flexibility for busy members and supported an increase in completed visits.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, Kaiser reported that it implemented the following interventions:

- Expanded visit hours and virtual care options.
- For the *Childhood Immunization Status* measure, Kaiser developed processes to expand well-visit and immunization reminders to members.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed two standards: Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

For Standard II—Access and Availability, Kaiser was required to complete 10 required actions:

- Ensure that reviewers consult with the requesting provider for medical services to obtain additional information when appropriate.
- Correct its policies and procedures to reflect the accurate time frames for making standard and expedited authorization decisions.
- Implement procedures, applicable to the CHP+ program, for providing telephonic or telecommunication notice of the authorization decision within 24 hours of receipt of complete information from the prescriber/requestor for making an authorization decision regarding covered outpatient drugs; and submit a written policy and procedure addressing this requirement.
- Simplify the content and language in the CHP+ NABD to comply with sixth-grade reading level requirements (to the degree possible).
- Update NABD and appeals information in the explanation of benefits (EOB) to reflect current regulations and correct the inaccuracies in appeal and SFH time frames and processes, as noted in the findings.
- Correct its policies and procedures to accurately address the 72-hour time frame requirement for providing the NABD to the member for expedited authorization requests.
- Develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including (four required actions):
  - For services administered within one hour of a request to Kaiser for pre-approval of poststabilization care.
  - Circumstances in which Kaiser does not respond to a request for pre-approval within one hour, Kaiser cannot be contacted, or Kaiser staff members and the treating physician cannot come to an agreement regarding the member's care.
  - Application of the criteria for when financial responsibility ends.
  - Ensuring that Kaiser does not charge the member more for poststabilization services delivered out of network than for services delivered in network.

Kaiser submitted its initial CAP proposal in March 2020. Following Department approval, Kaiser successfully completed implementation of all planned interventions in October 2020.

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 continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

To follow up on recommendations related to FY 2019–2020 CAHPS, Kaiser reported engaging in the following QI initiatives:

- Continues efforts to streamline referral processes and improve care coordination with The Children's Hospital.

Rocky Mountain Health Plans

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated Module 3 for the RMHP *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for RMHP to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out; however, the health plan provided a close-out report including interventions tested, successes, and lessons learned. Table 5-5 summarizes RMHP's PIP close-out report.

Table 5-5—RMHP FY 2019–2020 *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP Close-Out Summary

Interventions	Registry-based automated text outreach system for well-child visits.
Successes	• Established a registry-based automated text outreach system. • Gained information on which members could not be reached, which will be used to explore alternative outreach methods.
Lessons Learned	• Increased understanding and competence in using text platforms for large-scale outreach efforts. • Member response to text outreach was lower than expected, suggesting that additional refinement of outreach methods is needed to best reach the adolescent member population.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, RMHP reported that it implemented the following interventions:

- For the *Childhood Immunization Status* measure, mailing activities included:
  - New Baby Packet: Educational brochure mailed to the member's parent or guardian at 1month of age. Includes education on child safety, recommended immunizations by age 2, and promotes child's health and safety through routine well-child checks.
  - Child's First Birthday: Educational brochure mailed at 12 months of age and includes education on why to immunize, how immunizations work, what happens if the child is not immunized, and a recommended immunization schedule from the Centers for Disease Control and Prevention (CDC).
  - Age 16 Months to 2-year Immunizations Reminder: Incentive mailing brochure through which the member is eligible to receive a gift card upon completion and showing proof of receiving all CDC recommended immunizations by the child's second birthday.
- For the *Childhood Immunization Status* measure, other activities included:
  - Monthly Interactive Voice Response (IVR) and Postcard Mailing: Children who missed an immunization between 6 and 18 months of age receive a postcard mailing and IVR call.
  - Member Newsletter: 2020 winter edition had information referencing Colorado immunization information system database. Included information on importance of well-child checks and immunizations.
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Childhood Immunization Status* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
- For the *Immunizations for Adolescents* measure, mailing activities included:
  - Wellness That Rewards—Pre-Teen Wellness: Incentive mailing brochure sent to members 10 to 13 years of age through which the member is eligible to receive a gift card upon completion of an annual wellness visit. This mailing includes educational content on immunizations for meningococcal meningitis, Tdap, HPV, and influenza.
- For the *Immunizations for Adolescents* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Immunizations for Adolescents* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
- For the *Well-Child Visits in the First 30 Months of Life* measure, mailing activities included:
  - New Baby Packet—Well-Child Check Schedule: Educational brochure that includes recommended well-child visit schedules based on the Bright Futures and the American Academy of Pediatrics guidelines.

  - Child's First Birthday: Educational brochure mailed to member's parent or guardian at one year of age during their birthday month. Includes information on health education topics, immunizations, and well-child visits.
  - Monthly IVR and postcard mailing for RMHP members who are due for their 1-year-old well visit.
- For the *Well-Child Visits in the First 30 Months of Life* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Well-Child Visits in the First 30 Months of Life* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
  - RMHP posted a social media campaign in May 2021 educating on the importance of members of all ages to have an annual wellness visit.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, mailings included:
  - Ages 3 to17: Incentive and educational mailing brochures sent to members 3 to 17 years of age and includes information on annual wellness visits, health education topics, healthy habits, immunization reminders, oral care, and growth and development.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, other activities included:
  - Monthly IVR and postcard mailing for RMHP members who are due for their 1-year old-well visit.
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
- For the *Child and Adolescent Well-Care Visits* measure, mailing activities included:
  - Ages 3 to 21: Incentive and educational mailing brochures sent to members 3 to 21 years of age and includes information on annual wellness visits, health education topics, healthy habits, immunization reminders, oral care, behavioral health, growth and development, and avoidance of tobacco and vaping.
- For the *Child and Adolescent Well-Care Visits* measure, other activities included:
  - Pediatrics Team QIC subcommittee created in 2021 to focus on interventions for the pediatric population. *Child and Adolescent Well-Care Visits* is one of the focused measures in this group.
  - Completed educational webinar for providers to discuss coding practices in January 2021.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
  - RMHP posted a social media campaign in May 2021 educating on the importance of members of all ages to have an annual wellness visit.

- For the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, activities included:
  - Created Pediatrics Team QIC subcommittee in June 2021 and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.
- For the *Asthma Medication Ratio* measure, activities included:
  - The RMHP care management department deployed a chronic disease program for asthma in children from July 1, 2020 thru October 1, 2020.
  - Diabetes and Chronic Conditions QIC subcommittee created in 2021 to focus on interventions for members with diabetes and chronic conditions. *Asthma Medication Ratio* is one of the focused measures in this group.
  - Website Provider Tools: RMHP Clinical Practice Guidelines are posted for reference.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed two standards: Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

For Standard I—Coverage and Authorization of Services RMHP was required to complete three corrective actions:

- Correct UM policies to address the 10-calendar-day time frame for standard authorization decisions.
- Correct UM policies to address the 14-calendar-day extensions for both standard and expedited authorization decisions.
- Ensure NABDs are written in a manner that is easy for a member to understand (i.e., at or below the sixth-grade reading level).

RMHP submitted its initial CAP proposal in June 2020. Following Department approval, RMHP successfully completed implementation of all planned interventions in September 2020.

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 continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

To follow up on recommendations related to FY 2019–2020 CAHPS, RMHP reported engaging in the following QI initiatives:

- Implemented a process by customer service to notify provider relations when they are informed by members that a healthcare provider is not accepting new patients, or is requiring applications for acceptance. Provider relations will follow up with the provider to investigate and address the member's concern.
- During member welcome calls, customer service educates members on the importance of having a primary care relationship with a PCP. Customer service asks the member if they have a PCP and, if so, if they have an appointment coming up. If they do not have a PCP, customer service offers to help the member find one and connect them with the office to schedule an appointment.
- Discussed a CAHPS educational video series during value-based contracting office hours with practices. In addition, the videos are available on the RMHP website. The goal was to increase provider awareness of the CAHPS survey and encourage PCPs to deliver high quality patient-centered care.
- Made a Podcast series available on Podbean and the RMHP website. It includes interviews with healthcare professionals with tips about improving communication and building patient relationships.
- Included member experience topics in newsletter articles, learning collaborative events, and webinar series. Topics included leadership training, behavioral health skills training, care management training, medical assistant skills and training, and telehealth visits.

DentaQuest

Validation of Performance Improvement Projects

In FY 2019–2020, HSAG validated modules 1–3 for the DentaQuest *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP. HSAG recommended the following as the health plan moved on to testing interventions for the PIP:

- 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.

In response to the COVID-19 pandemic, the Department instructed the health plan to close-out the PIP early, after HSAG had completed the FY 2019–2020 validation and provided recommendations. It was not possible for DentaQuest to address HSAG's FY 2019–2020 recommendations due to the early PIP close-out. When the PIP was closed out in April 2020, DentaQuest had not yet progressed to testing interventions or determining outcomes for the project; therefore, the FY 2019–2020 PIP close-out report did not include interventions, successes, or lessons learned.

Validation of Performance Measures

To improve its HEDIS rates from the previous year, DentaQuest reported that it implemented the following interventions:

- DentaQuest worked with its providers to get into alignment around the importance of delivering and reporting services. DentaQuest has worked with customer service so that members receive more direct access to member-focused representatives for services that are available under their plan. Providers also have a separate line that they are able to call in from to speak with a representative in case they have a question on the CHP+ program, billing, or general questions.
- DentaQuest improved the member portal to provide a more in-depth experience for both members and providers so they are able to access their benefits.

- DentaQuest updated policies, member handbooks, and office reference manuals to provide more in-depth details that outline members rights and providers rights, ensuring that all federally required member rights and provider rights were accounted for within its Member and Provider Rights and Responsibilities policy. DentaQuest has submitted CAPs throughout FY 2020–2021 to ensure full compliance with standards.

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2019–2020, HSAG reviewed three standards: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems. HSAG identified opportunities for improvement that resulted in 35 required actions.

For Standard I—Coverage and Authorization of Services, DentaQuest was required to:

- Develop a mechanism for interdepartmental communication regarding member grievances and appeals so they may be addressed in a way that meets members' needs and meets the terms of the CHP+ contract (i.e., services that are sufficient in amount, duration, and scope).
- Ensure that reasons for denying services in part or in whole are accurately indicated to members and providers.
- Revise policies to align with required timelines for authorization determinations.
- Ensure NABDs include 1) language that is easy to understand and 2) accurate timeline information.

For Standard II—Access and Availability, DentaQuest was required to:

- Ensure providers are available in sufficient number, type, and specialty to furnish contracted services.
- Develop a mechanism to allow out-of-network providers to 1) furnish services if unavailable in network and 2) coordinate payment that is no greater than if the member received services in network.
- Develop a mechanism to ensure compliance with timely access standards and CAP steps if there is failure to comply.

For Standard VI—Grievance and Appeal Systems, DentaQuest was required to:

- Develop and implement training to 1) inform staff members of federal definitions related to grievances and appeals and 2) ensure all expressions of dissatisfaction are treated and logged as grievances in the system.
- Revise policies to include the provision for an authorized representative to file a grievance, appeal, or SFH and develop a mechanism to ensure this right is afforded to the member.
- Develop and implement a mechanism to provide members reasonable assistance in filing a grievance or appeal.

- Update policies, procedures, and develop tracking and training mechanisms for staff members to ensure the understanding of grievance, appeal, and SFH time frames, procedures, requirements, and contents of member letters (13 required actions).
- Ensure all comments, documents, and records are considered when deciding an appeal.
- Update member communications to clarify that grievances are not required in writing.
- Update internal policies and training staff members so they are informed that CHP+ only has one level of appeal.
- Develop a mechanism to track that acknowledgement letters for appeals are sent within two working days.
- Update policies, procedures, and trainings to ensure oral appeals are treated as the earliest filing date and pursued.
- Ensure members are afforded the right to provide additional evidence during the appeal process and informed of the right to receive records at no charge.
- Update policies and procedures to clarify the provisions of the expedited appeal process (two required actions).
- Revise policy, procedures, and other documents to include the representative of a deceased member's estate is a party to the SFH.
- Revise provider documents to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.

DentaQuest submitted its initial CAP in March 2020. HSAG and the Department approved portions of the CAP and DentaQuest successfully completed implementation of the approved planned interventions in December 2020. However, two required actions remained incomplete at the time of the virtual review in January 2021. The following two required corrective actions were carried through to the FY 2020–2021 CAP:

- Revise policies, procedures, member and provider informational materials, and member communications templates to accurately inform members that the request for an SFH must be in writing and is due within 120 days from the DentaQuest internal notice of appeal resolution.
- Revise provider documents to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.

Validation of Network Adequacy

During FY 2019–2020, DentaQuest 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. DentaQuest continued to fully participate in quarterly NAV activities throughout FY 2020–2021, beginning with quarterly network adequacy report and network data submission to the Department in July 2020.

CAHPS Surveys

DentaQuest is not required to participate in the CAHPS survey.