FY 2021–2022 External Quality Review Technical Report for Child Health Plan *Plus*

November 2022

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

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1. Executive Summary

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) requires 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" or managed care entities [MCEs]) 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 of, timeliness of, and access to services provided by the contracted health plans. To meet the requirements for EQR, the Colorado Department of Health Care Policy & Financing (the Department) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO. The latest reauthorization of CHIP managed care regulations occurred in 2018.

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

Colorado's CHP+ Program

In FY 2021–2022, the Department contracted 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 that provided services in FY 2021–2022. As of June 30, 2022, Friday Health Plans' (FHP's) contract with the State of Colorado to provide CHP+ services ended; however, FHP participated in the full array of state-required EQR-related activities, which are reported on in this technical report.

Table 1-1—FY 2021–2022 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 Activities for Colorado's CHP+ Health Plans

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 2021–2022, 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

[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 21, 2022.

the Department to update the quarterly network adequacy reporting materials used by the CHP+ health plans.

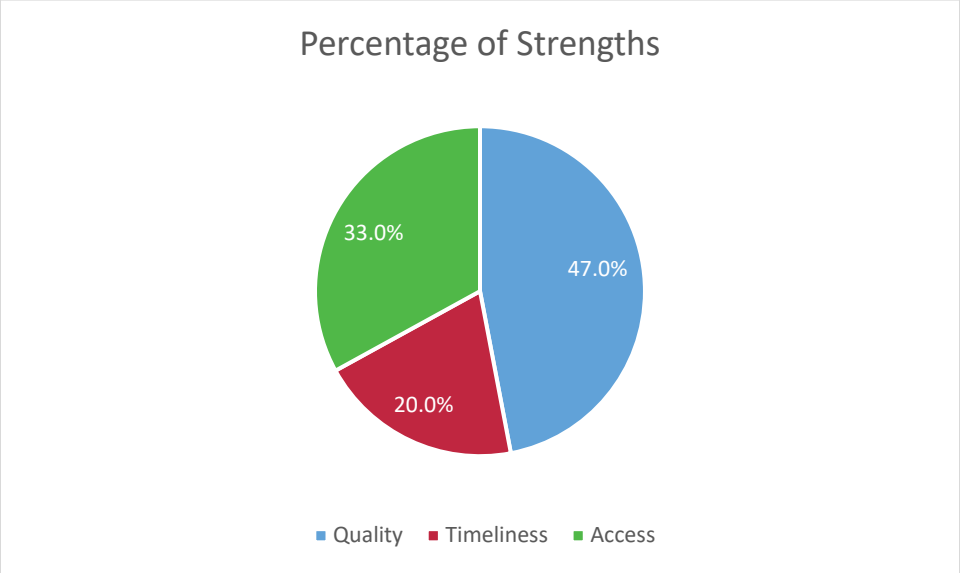
The optional activities conducted for the CHP+ health plans were:

- **CAHPS surveys (Protocol 6).** HSAG conducted CAHPS surveys and reported results for all CHP+ health plans on behalf of the Department.
- **EQR Dashboard (Protocol 9).** HSAG designed the EQR Dashboard to allow the Department to monitor and track the CHP+ health plans' performance across a variety of EQR activities including performance measures, CAHPS, compliance audits, and PIPs.

Summary of FY 2021–2022 Statewide Performance by External Quality Review Activity With Trends

Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weaknesses (opportunities for improvement) that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted during FY 2021–2022.

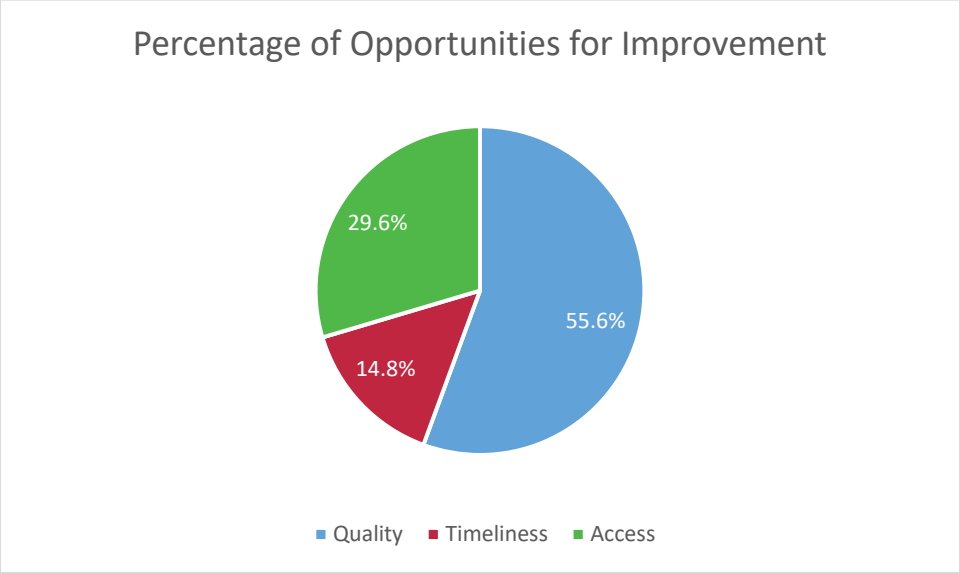
Figure 1-1—Percentage of Strengths by Care Domain*



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

Figure 1-2 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality of, timeliness of, and access to care and services provided by the CHP+ program.

Figure 1-2—Percentage of Opportunities for Improvement by Care Domain*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Table 1-2 summarizes PIP performance for each CHP+ health plan in FY 2021–2022. 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—FY 2021–2022 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, Module 2, and Module 3*	NA
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
FHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Kaiser	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	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, Module 2, and Module 3*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2021–2022 validation cycle.*

During this validation cycle, the CHP+ health plans continued ongoing PIPs, submitting Module 3 of the rapid-cycle PIP process for validation. In Module 3, each CHP+ health plan defines the plan for the intervention to be tested. During FY 2021–2022, HSAG provided technical assistance and feedback to the CHP+ health plans on the intervention testing plan, including the intervention effectiveness measure and data collection process. The CHP+ health plans continued testing interventions for the PIPs until the end of the fiscal year. In FY 2022–2023, the CHP+ health plans will submit the final rapid-cycle PIP module, Module 4—PIP Conclusions for validation and will report the final results, conclusions, and lessons learned for the PIPs.

Statewide Strengths Related to Validation of PIPs

Based on the PIP validation activities completed in FY 2021–2022, HSAG found the following strengths:

- All CHP+ health plans selected PIP interventions to address key drivers and failure modes related to depression screening and follow-up care processes and facilitated achievement of the SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim goals for improvement.
- All CHP+ health plans initiated testing of PIP interventions and developed a methodologically sound plan for evaluating the effectiveness of each intervention through Plan-Do-Study-Act (PDSA) cycles.

Statewide Opportunities for Improvement and Recommendations Related to Validation of PIPs

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. All CHP+ health plans addressed all Module 3 PIP validation criteria.

To support successful progression of the PIPs in the next fiscal year, HSAG recommends the CHP+ health plans:

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

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 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 measurement year (MY) 2019 through MY 2021, along with the percentile ranking for each MY 2021 rate for the high- and low-performing measure rates. Statewide performance measure results for MY 2021 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for MY 2020 when available for HEDIS measures. Additionally, rates for MY 2021 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for MY 2021 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-2] HSAG also compared statewide performance measure results for MY 2021 to the CMS Core Set Medians for federal fiscal year (FFY) 2020 when available. 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 for the MY 2021 High-Performing Rates

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Childhood Immunization Status ^{H}				
Combination 10	41.97%	50.95%	48.48%	75th–89th
Developmental Screening in the First Three Years of Life ^{CS}				
Total	—	—	57.54%	ACSM

[1-2] For HEDIS measures, 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	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Maternal and Perinatal Health				
Contraceptive Care—All Women[CS]				
Long-Acting Reversible Method of Contraception (LARC)—Ages 15 to 20 Years	—	—	5.49%	ACSM
Care of Acute and Chronic Conditions				
Asthma Medication Ratio				
Total (Ages 5 to 18 Years)[CS]	—	—	75.43%	ACSM
Behavioral Health Care				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	71.01%	75th–89th

[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
ACSM indicates the reported rate was above the Core Set Median.

Table 1-4—Colorado CHP+ Statewide Weighted Averages for the MY 2021 Low-Performing Rates

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Childhood Immunization Status[H]				
Combination 3	61.81%	69.20%	**64.91%^^**	25th–49th
Combination 7	53.94%	62.62%	**57.91%^^**	25th–49th
Chlamydia Screening in Women[H]				
Ages 16 to 20 Years	37.26%	35.29%	36.58%	<10th
Immunizations for Adolescents[H]				
Combination 1 (Meningococcal, Tetanus, Diphtheria, and Pertussis [Tdap])	74.81%	76.12%	73.38%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[H]				
Body Mass Index (BMI) Percentile Documentation—Total	22.62%	24.29%	26.61%	<10th
Counseling for Nutrition—Total	20.77%	22.75%	26.82%^	<10th
Counseling for Physical Activity—Total	16.17%	17.76%	21.63%^	<10th
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	73.12%	**63.58%^^**	10th–24th
Maternal and Perinatal Health				
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	54.95%	<10th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Contraceptive Care—All Women[CS]				
Most or Moderately Effective Method of Contraception (MMEC)—Ages 15 to 20 Years	—	—	24.39%	BCSM
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				
7-Day Follow-Up—Ages 6 to 17 Years	—	—	41.15%	10th–24th
30-Day Follow-Up—Ages 6 to 17 Years	—	—	58.85%	10th–24th
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication[H]				
Initiation Phase	14.98%	36.45%	32.05%	<10th
Continuation and Maintenance Phase	32.69%	50.85%	40.79%	10th–24th

[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
BCSM indicates the reported rate was below the Core Set Median.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.

Statewide Strengths Related to Measure Rates and Validation

The following HEDIS MY 2021 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 MY 2020 or ranked between the 50th and 74th percentiles with significant improvement in performance from MY 2020):

- *Childhood Immunization Status—Combination 10* 
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* 

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates (i.e., ranked at or above the Core Set Median):

- *Developmental Screening in the First Three Years of Life* 
- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years* 
- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)*

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

The following HEDIS MY 2021 measure rates were determined to be low-performing rates (i.e., ranked below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS MY 2020 for the MCOs):

- *Childhood Immunization Status—Combination 3* and *Combination 7* 
- *Chlamydia Screening in Women—Ages 16 to 20 Years* 
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* 
- *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* 
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* 
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* 
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years* and *30-Day Follow-Up—Ages 6 to 17 Years* 
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* 

The following non-HEDIS MY 2021 Core Set measure rate was determined to be a low-performing rate (i.e., ranked below the Core Set Median):

- *Contraceptive Care—All Women—MMEC—Ages 15 to 20 Years* 

To address these low measure rates, HSAG recommends:

- Reminding parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[1-3]

[1-3] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 24, 2022.

- Promoting well-care visits with providers as an opportunity for providers to influence health and development and reinforcing that well-care visits are a critical opportunity for screening and counseling.[1-4]

Assessment of Compliance With CHIP Managed Care Regulations

In FY 2021–2022, HSAG reviewed four standards as directed by the Department. Compliance standards were reviewed using a three-year rotation (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 was reviewed as compared to the previous review's results for the same standard.[1-5] For individual CHP+ health plan scores and findings, see Section 3. For CHP+-level comparison of scores for FY 2021–2022, see Section 4, Table 4-3.

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—Adequate Capacity and Availability of Services (2013–2014, 2016–2017, 2019–2020)	93%	90%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**80%**	**90%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**90%**	**88%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	95%	84%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	84%	79%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	90%	91%

[1-4] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 24, 2022.

[1-5] FY 2019–2020 was the first year 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.

Standard and Applicable Review Years*	Statewide Average—Previous Review	Statewide Average—Most Recent Review**
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**97%**	**95%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA***	79%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	**87%**	**92%**

**Bold text indicates standards reviewed by HSAG during FY 2021–2022.*

***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.*

In FY 2021–2022, Colorado's CHP+ MCOs demonstrated moderate to high scores (ranging from 88 to 95 percent compliance) in the four standards reviewed. Two standards increased by 5 and 10 percentage points (Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems and Standard III—Coordination and Continuity of Care), and two standards decreased by 2 percentage points each (Standard IV—Member Rights, Protections, and Confidentiality and Standard VIII—Credentialing and Recredentialing). For all standards reviewed in previous fiscal years, all standards scored at or above 78 percent compliance, demonstrating a consistent understanding of State and federal regulations.

Statewide Strengths Related to Compliance With Regulations

Through review of the four standards, HSAG found the following statewide strengths among the CHP+ health plans:

- Standard III—Coordination and Continuity of Care increased by 10 percentage points from 80 to 90 percent compliance; many health plans described improvements in organizational structures, procedures, and monitoring mechanisms since the previous review. 
- Standard IV—Member Rights, Protections, and Confidentiality scored 88 percent compliance across the state and each CHP+ health plan described member-focused forums where rights were discussed and monitored regularly. 
- Standard VIII—Credentialing and Recredentialing remained the highest scoring overall standard at 95 percent compliance, indicating strong alignment with both State requirements and the NCQA guidelines. 

- Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems was the second highest scoring standard in FY 2021–2022, demonstrating the CHP+ MCOs' strength in data-driven monitoring of member's healthcare services.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

Through review of the four standards, HSAG found the following opportunities for improvement:

- Some health plans did not send any follow-up information to members after care coordination outreach calls to engage members identified as needing care coordination.
- Two CHP+ health plans lacked overall care coordination structure, policies, procedures, and processes for the monitoring of members.
- Although requirements differed slightly during the FY 2021–2022 review cycle, compliance with Standard IV—Member Rights, Protections, and Confidentiality decreased by 2 percentage points since the previous review cycle. One CHP+ MCO demonstrated a need for ongoing monitoring and updates to member rights policies and procedures.
- One CHP+ health plan lacked a mechanism to track disenrollment for reasons other than loss of eligibility.

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

- Encourage the CHP+ health plans to consider sending a follow-up letter with care coordination details to each member identified as needing care coordination.
- Work with two CHP+ health plans to develop an adequate care coordination structure, monitoring, and reporting process to align with expectations.
- Encourage the CHP+ MCOs to review policies and procedures annually.
- Consider providing additional information to the CHP+ health plans about reasons for disenrollment, other than the loss of eligibility.
- Work with the dental PAHP to ensure quality assessment and performance improvement (QAPI) key elements are assessed for Colorado CHP+ members.

Validation of Network Adequacy

Statewide Strengths Related to Validation of Network Adequacy

Based on network adequacy validation (NAV) activities completed in FY 2021–2022, HSAG found the following statewide strengths:

- All CHP+ and PAHP health plans participated in the statewide NAV.
- The Department demonstrated significant growth in its oversight of the CHP+ MCOs' and PAHP's networks through the development and implementation of standardized quarterly network adequacy reporting materials.
- In the FY 2021–2022 time and distance analysis, the Colorado CHP+ MCOs and PAHP exhibited improvements in member access compared to the same activity performed in FY 2020–2021.
- Across the CHP+ MCOs, urbanicities, and practitioner network categories, there were notable improvements in the percentage of network requirements assessed for which the MCEs were meeting the Department's 100 percent standard, particularly for the physical health primary care provider type.
- Within the physical health specialist provider type, the CHP+ MCOs exhibited marked increases in the percentage of network requirements with 100 percent of members meeting the standards.
- Within the behavioral health (BH) provider type, the CHP+ MCOs demonstrated notable gains in the percentage of network requirements for which 100 percent of members were within the time and distance standards.

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

HSAG found the following opportunities for improvement:

- The MCEs' network data quality could be further enhanced by cross-referencing against the Department's interChange data[1-6] to confirm MCE practitioner network National Provider Identifiers (NPIs), practitioner identification values, practitioner addresses, and taxonomy codes to determine the extent to which each MCE's network aligns with the practitioner/practice site/entities enrolled in interChange.

[1-6] *interChange* is the Department's Medicaid Management Information System (MMIS). All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs. While *interChange* offers a direct alignment with the Network Crosswalk for selected network categories, not all network categories are directly identified from the *interChange* data fields.

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

To address these opportunities for improvement, HSAG recommends:

- The Department consider continuing the development and implementation of a formal network exception policy and request templates to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards.
- The Department consider the extent to which the MCEs offer alternate service delivery mechanisms to ensure members' access to care when minimum network requirements may not be the most appropriate method of measuring access for certain geographic areas and/or network provider categories.
- The Department consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population needs. Although current network standards developed by the Department were designed to assess the number of specific provider types located within given driving times and distances from members, the adequacy of the networks to address specific population needs may be more comprehensively assessed by including and cross-referencing encounter data to assess actual utilization patterns.

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 2019–2020 through FY 2021–2022.[1-7]

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

Measure	FY 2019–2020 Statewide Aggregate Score	FY 2020–2021 Statewide Aggregate Score	FY 2021–2022 Statewide Aggregate Score
Rating of Health Plan	63.3%	67.0%	67.5%
Rating of All Health Care	68.8%	72.7%	65.7% ▼
Rating of Personal Doctor	77.6%	77.4%	75.3%
Rating of Specialist Seen Most Often	71.6%	69.6%	65.5%
Getting Needed Care	83.7%	80.1%	82.9%
Getting Care Quickly	90.9%	86.6%	84.5%

[1-7] No CAHPS survey was conducted for Colorado's dental PAHP, DentaQuest.

Measure	FY 2019–2020 Statewide Aggregate Score	FY 2020–2021 Statewide Aggregate Score	FY 2021–2022 Statewide Aggregate Score
How Well Doctors Communicate	97.5%	94.1%	96.8% ▲
Customer Service	82.3%	87.2%	90.4%

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

Statewide Strengths Related to CAHPS Surveys

The statewide aggregate rate scored statistically significantly higher in FY 2021–2022 than in FY 2020–2021 on the following measure:

- *How Well Doctors Communicate*

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

The statewide aggregate rate scored statistically significantly lower in FY 2021–2022 than in FY 2020–2021 on the following measure:

- *Rating of All Health Care*

To address this opportunity for improvement, HSAG recommends the Department:

- Collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of quality of care (QOC).
- Determine if any MCO best practices should be shared or interventions or actions duplicated to improve measure scores.

For additional information about CHP+ CAHPS results for FY 2021–2022, 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 and cannot afford private health insurance. In FY 2021–2022, Colorado provided 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.

Colorado's Six Pillars

Figure 1-3 displays the six pillars the Department has defined to help focus its work on the Department's mission: *Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* The pillars are reflected in the quality strategy goals selected by the Department.

Figure 1-3—Colorado's Six Pillars

Pillar: Member Health

- Implement Health Equity Plan
- Transform BH
- Implement quality improvement (QI) initiatives
- Advance hospital transformation program

The Department developed a new FY 2022–2023 Health Equity Plan (HEP) that applies a health equity lens across all programs and initiatives. The HEP aligns with the Governor's Executive Order 175, SB 21-18 which focus on addressing health disparities. The Department includes the HEP requirements and initiatives in its MCE contracts as of July 1, 2022. The HEP addresses stratifying data using data analytics to identify and address disparities. The HEP focuses the Medicaid program's efforts on vaccinations (COVID-19), maternity and perinatal health, BH, and prevention. These efforts include ongoing work to close COVID-19 vaccination disparity gaps, maternity research and reporting, BH investments transformation, increasing access to prevention, and expansion of quality care. These efforts may lead to performance measure rate improvement as the work progresses.

The Department implemented targeted and intentional conversations to engage stakeholders in meaningful dialogue, feedback, and grassroots strategy. These conversations occurred in town halls, listening sessions, public meetings, and on the Department's Health Equity website. The Department encouraged conversations and feedback from members with lived experience, MCEs, and community stakeholders from all intersectional identities. These targeted and intentional conversations may result in increases in member satisfaction and member experience survey results.

The Department developed robust dashboards that stratified data to provide the current or most updated disparity data and embedded a health equity lens in metric deliverables and analytics. The Department stratified quality data, CMS Core Set measure data, and Department goals and measurements by race/ethnicity, gender, language, geography, disability, and other available identifiers. The dashboard provides additional data that can be used by the CHP+ plans to target interventions to improve performance measure rates.

The Department's BH transformation includes increasing dollars in BH care; increasing the number of active BH providers to over 10,000, which is an increase of over 1,100 during the last year; and growing the safety net, with federal supports. The Department used federal stimulus dollars for community grant funding, mobile crisis and secure transport, increasing high-intensity outpatient services, preventing hospitalization, giving people additional wraparound services, step-down services for youth with complex needs, culturally competent training for providers, and integrated care grants. NAV should be positively impacted by these efforts.

The Department's QI priorities included enhancing the ability to measure CMS adult and child Core Set measures; enhancing the transparency around quality metric performance; aligning CHP+, and other incentive program metrics with the CMS Core Measures; and including more detailed member experience data (CAHPS) such as member experience in culturally sensitive care.

Pillar: Care Access

- Expand and support health care workforce
- Increase number and percentage of providers seeing members
- Transform residential, community-based care
- Redesign case management

The Department worked with the CHP+ health plans to expand the network of care. The Department expanded access to care by growing the provider network by 28 percent over the last few years. The Department has approximately 95,000 providers enrolled in the provider network, of which approximately 11,700 were added during the last year. The Department has approximately 10,000 active BH providers, of which 1,100 were added in the last year. To further increase access to care, two-thirds of telemedicine visits were for BH services. NAV should be positively impacted by these efforts. It is also anticipated that member experience survey results may reflect improvement in members' experience in access to care.

The Department continued to craft programs and services to support people with disabilities to live in their homes and their communities. To accomplish this, the Department implemented widespread rate increases, identified as a national leader in electronic visit verification processes, and provided much needed support for the direct care workers. Figure 1-4 contains the Department's direct care workforce goals:

Figure 1-4—Direct Care Workforce Goals

The Department established a case management redesign framework. The policy framework included the categories of:

- New structure.
- Knowledge.
- Conflict free.
- Accountability.

The assessment and support plan framework included a new:

- Assessment tool.
- Person-centered budget algorithm.
- Information technology system.

Colorado is also investing significant dollars to support rural hospitals. Other rural investments include expanding broadband to support telemedicine policies. The Department has invested heavily in a rural support fund for technology, telemed, analytics, staff, BH, and more. The Department's investment includes increasing health information technology/health information exchange connectivity with the Colorado Office of eHealth Innovation (OeHI). An investment has also been made to connect the remaining 60 independent rural providers with OeHI. These investments may result in improved network adequacy, member access to care performance measures, and member experience.

Pillar: Operational Excellence and Customer Service

- Enable coverage continuity
- Make eligibility and enrollment easy
- Improve Medicaid enterprise solutions
- Ensure service quality network-wide

The Department expanded efforts to connect children and families to coverage. The Department's work was supported by the historic passing of Health Benefits for Colorado Children and Pregnant People (HB22-1289), which waives CHP+ enrollment and renewal fees, creates a lactation benefit, and creates Medicaid and CHP+ look-alike programs for children and pregnant people without documentation.

The Department expanded coverage for family planning and related services for more people. Colorado also increased coverage after pregnancy/birth from 90 days to 12 months. These coverage expansions enabled coverage continuity for members.

The Department handled an approximate 30 percent membership growth and completed 137 Medicaid enterprise system updates without major operational issues. The Medicaid enterprise system updates focused on solutions, innovation, system integration, and interoperability. Examples of this work include making BH claims submission and payment easier and ensuring the Department's system updates and

MCE system migrations are completed without disruptions. The Medicaid enterprise system updates improving claims submission processes should result in improved EDV results.

The Department also focuses on improving member experience with the Medicaid and CHP+ programs. On average, the hold time for calls into the Member Contact Center during FY 2022 was 35 seconds. The Member Contact Center representatives actively listen to members and escalate complaints when needed. The Department holds all partners to these same high member experience standards.

Pillar: Health First Colorado Value

- Expand value-based payments and insights
- Implement eConsult and telehealth strategy
- Develop accountable care collaborative 3.0 strategy
- Produce cost and quality indicators

The Department continued development of eConsult to support primary care providers (PCPs) and to improve the referral process. eConsult allows asynchronous electronic clinical communications between primary care medical providers (PCMPs) and specialists. eConsult will be used by the Department to enable referrals to higher performing docs, reducing disparities and improving quality. These efforts are expected to expand care in the PCP office by improving access while reducing the specialist "no-shows." The Department anticipates supporting eConsult through value-based payments that reward results. The Department anticipates the eConsult platform to go live in the summer or fall of 2023.

Colorado continued to shift payments from volume to value. The Health First Colorado Value Based Care initiative includes payment based on better care for members, reducing healthcare disparities, and care affordability. The Department's primary care alternative payment process allows PCPs to choose to receive some or all of their revenue as a per member per month (PMPM) payment which results in stable revenue, increased investment in care improvement, and the ability of PCPs to share in savings from improved chronic care management by providing high quality person-centered care. In addition, the Department's maternity bundled payments covers all prenatal care. This value-based care option rewards providers for improving outcomes and closing health disparities.

Pillar: Affordability Leadership

- Reduce commercial pharmacy costs
- Promote transparent hospital prices
- Advance community and rural investment
- Propel and align value-based payments

The Department also focused efforts on safety net accountability. This work included advancing value-based payments for safety net providers. This will allow more flexible funds, based on patient outcomes, beginning in July 2023. The Department is using universal contracts to reduce administrative burden for

providers in the public health system, which contains clear and aligned roles for all parties and is connected to value-based payments.

Colorado implemented a new hospital price transparency law. The Department also created a new hospital price dataset and tools. Although the Medicaid overall prescription trend is flat, the State made progress on opportunities to reduce prescription drug costs including implementing Medicaid value-based contracts that hold drug manufacturers accountable for clinical outcomes while rewarding prescribers for being part of the affordability solution. The MCE contracts include provisions to ensure that 100 percent of prescription rebates are used to lower costs for employers and consumers. Colorado also implemented a Prescription Drug Affordability Board, which has the authority to review prescription drugs and evaluate if certain drugs are unaffordable to Coloradans, establish upper payment limits for drugs, and make policy recommendations to the Colorado General Assembly.

Pillar: Employee Satisfaction

- Quickly and carefully fill open positions
- Accelerate equity, diversity, inclusion, accessibility
- Address manager workload
- Foster career growth and flexibility

Goals, Objectives, and Statewide Recommendations

The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve the quality of, timeliness of, and access to care based on the Department's strategic QI goals and associated objectives. Based on EQR findings for FY 2021–2022, HSAG recommends the following to target and improve statewide performance and achieve the Department's quality strategy selected goals and objectives.

Goal 1: Decreasing health care cost and increasing affordability for individuals, families, employers and government

HSAG Recommendations

- Consider implementing pay-for-performance (P4P) programs through PMPM enhanced payment for meeting key performances indicator goals. The Department should consider low-performing HEDIS and Core Set performance measures as a potential focus in its P4P programs. Implementing P4P programs supports the Department's Health First Colorado pillar focused on expanding value-based payments and insights.
- Consider enhancing and expanding incentive measure programs for BH and MCO physical health to decrease costs and increase care affordability. Enhancing and expanding incentive measures supports the Department's Affordability Leadership pillar regarding propelling and aligning value-based payments.

Goal 2: Enhancing delivery system innovation

- Increase and monitor members' access to care and provider network adequacy.
- Increase and strengthen partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care.
- Protect and improve the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.
- Implement P4P with providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients.

HSAG Recommendations

- Continue to collaborate with the health and dental plans to support adequate QI capacity, skills, and resources to support current and future PIPs. Continue to 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. These QI activities support the Department's Member Health pillar, implement QI initiatives, by providing opportunities to improve population health through the implementation of best practices and addressing barriers and challenges.
- To address identified access to care concerns, the Department could consider continuing to critically evaluate and refine network adequacy oversight and enhance Colorado-specific minimum network requirements to reflect Colorado's unique healthcare delivery system and geography. This recommendation supports the Department's Care Access pillar by increasing the number and percentage of providers seeing members.
- In addition to continuing efforts to expand the contracted provider network, the Department is encouraged to work with health plans and dental plans to develop a plan to address network gaps, particularly in rural and frontier counties, that considers expanded transportation to needed providers, single case agreements for needed care, and telehealth services. Efforts to expand the contracted network align with the Department's Care Access pillar by expanding and supporting the healthcare workforce.
- Encourage the MCOs and PAHP to invest in neighborhood health through community-based partnerships by supporting proven interventions that address social determinants of health (SDOH) and healthy lifestyles that improve population health, as addressing SDOH supports the Department's Member Health pillar through the implementation of the HEP.

Goal 3: Improving Patient Safety

- Ensure members are connected to the right care, at the right time, every time
- Promote effective prevention and treatment of chronic disease

HSAG Recommendations

- Continue health and dental plan monitoring by conducting routine plan-specific performance review meetings that focus plan efforts to improve performance on targeted objectives in selected performance metrics. Focusing on performance metrics included in HEDIS or the CMS Core Set measures, which are based on evidence-based and recommended care guidelines, will strengthen the health plan's opportunities to promote effective prevention and treatment of chronic disease.
- Consider rewarding or recognizing creative care coordination programs that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions; assess and refer members to appropriate community partners to address SDOH; and connect members to the right care, at the right time, every time. Focusing on creative and effective care coordination programs supports the Department's Care Access pillar by expending and supporting the healthcare workforce and efforts to redesign case management.

Goal 4: Improving health outcomes, member experience and patient safety through clinical analytics, evidence-based practices and adoption

HSAG Recommendations

- In addition to the use and adoption of evidence-based practices and guidelines, the Department should consider encouraging health plans to develop an adequate care coordination structure, monitoring, and reporting processes. The MCOs should also be encouraged to send a follow-up letter with care coordination details to each member identified as needing care coordination. Members' perceptions of care coordination processes may impact member experience survey measures. These efforts support the Department's Care Access pillar if included in case management redesign work.

2. Reader's Guide

Report Purpose and Overview

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 mandatory and optional EQR-related activities that HSAG conducted with the CHP+ health plans throughout FY 2021–2022.

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 2021–2022 with a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQR activities in FY 2021–2022. 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 of, 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 of, 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 2021–2022. This information is presented for each health plan and provides an activity-specific assessment of the quality of, timeliness of, and access to care and services for each health plan as applicable to the activities performed and results obtained.

Section 4—Statewide Comparative Results, Assessment, Conclusions, and Recommendations includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results for each CHP+ health plan and statewide averages. This section also identifies, through presentation of results for each EQR activity, statewide trends and commonalities used to derive statewide conclusions and recommendations.

Section 5—Assessment of CHP+ Health Plan Follow-Up on FY 2020–2021 Recommendations provides, by EQR activity, a health plan-specific assessment of the extent to which each health plan was able to follow up on and complete any recommendations or corrective actions required as a result of the FY 2020–2021 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 [prepaid inpatient health plan], PAHP [prepaid ambulatory health health plan], or PCCM [primary care case management] entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]

Access

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

Timeliness

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

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

[2] Ibid.

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

Methodology

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

Validation of Performance Improvement Projects

Objectives

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

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

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

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that any reported improvement is related, and can reasonably be linked to, the 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 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), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.

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

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission forms. In FY 2021–2022, 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 2021–2022 CHP+ PIP SMART Aim Statements and Data Sources

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

Health Plan	SMART Aim	Data Sources
	depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers from 73.58% to 90.57%.	
DHMP	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH [patient-centered medical home], from 62.11% to 70.18%.	Enrollment data, claims data, and electronic medical record (EMR) data
	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health CHP+ members aged 12–21 assigned to the Westside Pediatrics PCMH from 55.56% to 81.48%.	Enrollment data, claims data, and EMR data
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
RMHP	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP members 12 years of age or older from 0.78% to 25.0%.	Claims and enrollment data
	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP members 12 years of age or older who screen positive for depression that are successfully connected to appropriate BH services within 30 days to the established benchmark of 46.89%.	Claims and enrollment data

Health Plan	SMART Aim	Data Sources
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.[2-1]

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 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.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 24, 2022.

  - 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 projects reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG 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 BH services) addressed access to care and timeliness of care (receiving timely follow-up BH services after a positive depression screen). DentaQuest selected a different topic relevant to the scope of services it provides as a dental PAHP, which also addressed access to dental care, in addition to addressing the quality domain. The assignment of domains for each PIP is shown in Table 2-2.

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

Health Plan	Performance Improvement Project	Quality	Timeliness	Access
COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓
FHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	✓	✓	✓

Health Plan	Performance Improvement Project	Quality	Timeliness	Access
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 calculated 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 (LO). CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,[2-2] identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the FAR for each health plan and aggregated several sources of HEDIS-related data to confirm that the health plans met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS audits in MY 2021 (due to COVID-19) regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[2-3]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.

[2-2] 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 24, 2022.

[2-3] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

- 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 and non-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 and non-HEDIS measure data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS and non-HEDIS MY 2021 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The health plans were responsible for obtaining and submitting their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the health plan's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, it did review the audit reports produced by the other licensed audit organizations. Through review of each health plan's FAR, HSAG determined that all 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 2021 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. Additionally, if applicable, all HEDIS measures where CMS Core Set stratifications differed from HEDIS and all non-HEDIS measures' source code were reviewed and approved.

3. **Rate Files from Previous Years and Current Year:** Final rates provided by health plans in IDSS format were reviewed to determine trending patterns and rate reasonability. Please note that all rates HSAG included in this report were those rates according to the CMS Child Core Set specifications. Age stratifications for the Core Set measures may differ from HEDIS age stratifications.

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the audited HEDIS results submitted to the Department by the five CHP+ MCOs and the one dental PAHP (collectively referred to as "health plans" or MCEs), 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 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.[2-4] This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the specific size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

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

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

[2-4] DentaQuest was required to calculate and report dental services-specific rates; therefore, DentaQuest rates are not included in any statewide rates.

Measure results for MY 2021 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020. Additionally, results for non-HEDIS MY 2021 measures were compared to CMS State Core Set Medians for FFY 2020, when available. 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 submission or NCQA recommended a break in trending in MY 2021. This symbol may also indicate that a percentile ranking was not determined, either because the MY 2021 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 2020.
  - Ranked between the 50th and 74th percentiles with statistically significant improvement in performance from HEDIS MY 2020.
- 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 2020.

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 MY 2019, MY 2020, and MY 2021 measures be reported using the administrative methodology only. When reviewing 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 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—Measures That Can Be Reported Using the Hybrid Methodology

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

- National HEDIS percentiles are not available for the CHIP population; 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
Primary Care Access and Preventive Care			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Chlamydia Screening in Women	✓		
Colorectal Cancer Screening	✓	✓	✓
Immunizations for Adolescents	✓		
Screening for Depression and Follow-Up Plan	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Maternal and Perinatal Health			
Contraceptive Care—All Women	✓	✓	✓
Contraceptive Care—Postpartum Women	✓	✓	✓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	✓	✓	✓
Care of Acute and Chronic Conditions			
Asthma Medication Ratio	✓		

Performance Measure	Quality	Timeliness	Access
Behavioral Health Care			
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Services			
Ambulatory Care: Emergency Department (ED) Visits	NA	NA	NA

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

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, MY 2019, MY 2020, and MY 2021 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for MY 2019, MY 2020, and MY 2021, 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.

Assessment of Compliance With CHIP Managed Care Regulations

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

Table 2-5—Compliance Standards

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

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

For the FY 2021–2022 compliance review process, the standards reviewed were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VIII—Credentialing and Recredentialing; and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. 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 provide the Department with information about the health plans' performance related to credentialing and recredentialing.

Objectives

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

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

Technical Methods of Data Collection

To assess for health plans' compliance with regulations, HSAG conducted the five activities described in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-5] 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 web-based conferencing to conduct the FY 2021–2022 compliance reviews. All protocol activities, requirements, and agendas were followed. Before the virtual compliance review designed to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, record review tools, report templates and virtual review agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's IQuIC meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the interview portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and a compliance review agenda. The document request included instructions for organizing and preparing the documents related to the review of the four standards and record reviews. Thirty days prior to each scheduled compliance review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the virtual portion of the review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 24, 2022.

For this step,	HSAG completed the following activities:
	member and provider informational materials. The health plans also submitted a list of providers who were credentialed and recredentialed between January 1, 2021, and December 31, 2021 (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 interview portion of the review and prepared a request for further documentation, if needed, as well as an interview guide for HSAG's use during the review.
Activity 3:	**Conduct Virtual Compliance Review**
	• During the interview portion of the review, HSAG met with 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 to evaluate credentialing and recredentialing practices. • HSAG also requested and reviewed additional documents as needed, based on interview responses. • At the close of the interview portion of the review, HSAG met with the health plan's staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 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 contracts, agreements, manuals, and directories
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (credentialing and recredentialing)
- Interviews with key health plan staff members conducted virtually

How Data Were Aggregated and Analyzed

For each health plan, HSAG compiled findings for all data obtained from the initial desk review, 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 (where available) to determine if the health plans' overall compliance improved across multiple review cycles.

How Conclusions Were Drawn

To draw conclusions about the quality 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

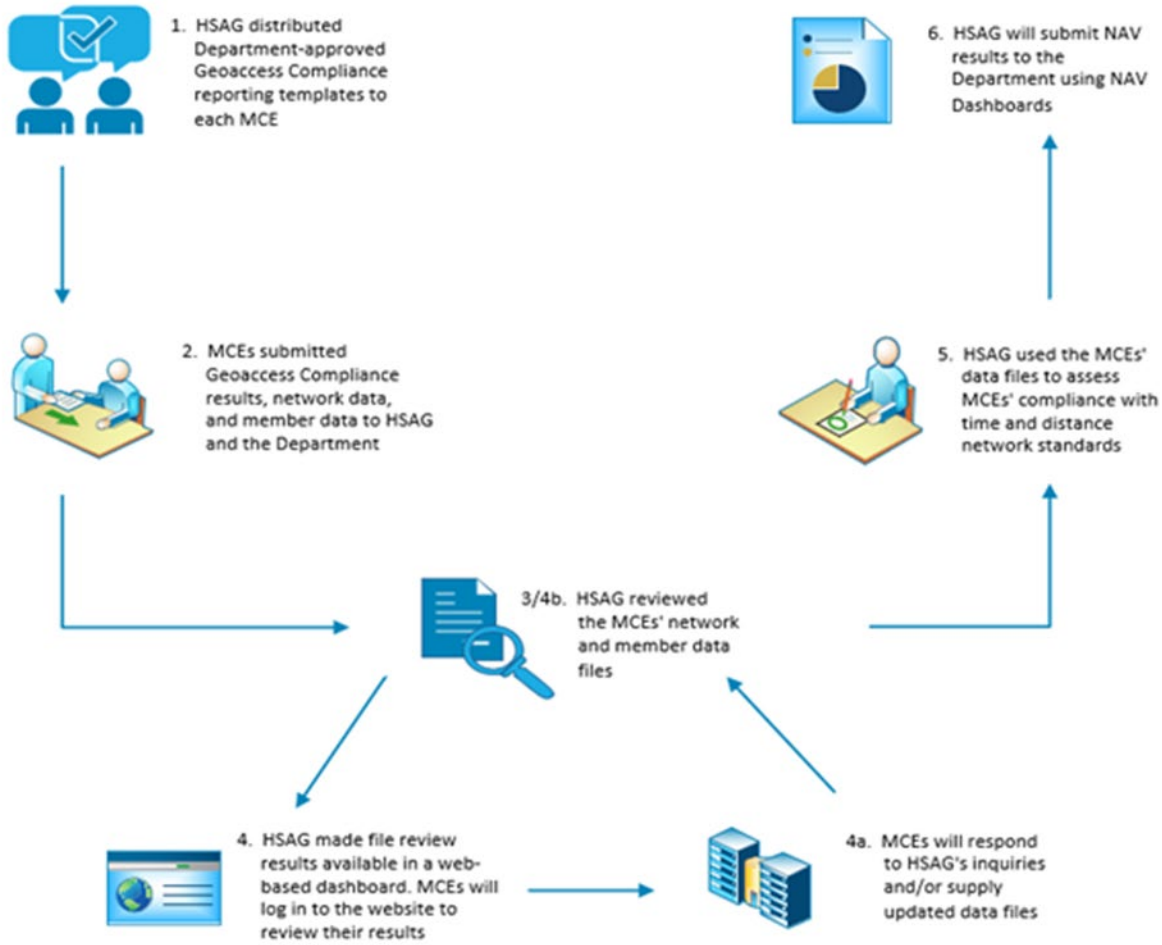
Compliance Review Standard	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Member Rights, Protections, and Confidentiality	✓		✓
Standard VIII—Credentialing and Recredentialing	✓	✓	✓
Standard X—Quality Assessment and Performance Improvement	✓	✓	✓

Validation of Network Adequacy

Objectives

The purpose of the FY 2021–2022 NAV was to determine the extent to which HSAG agreed with the health plans' (also referred to as "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 the key steps in HSAG's quarterly NAV process.

Figure 2-1—Summary of FY 2021–2022 NAV 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.[2-6,2-7] Table 2-8 presents the network domains applicable to CHP+ health plans; within each domain, network categories included in the FY 2021–2022 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

Beginning in FY 2018–2019, HSAG collaborated with the Department to develop and maintain a Network Crosswalk and quarterly 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.

Concurrent with requesting the health plans' network and member data, HSAG requested Medicaid member files from the Department using a detailed member data requirements document for members actively enrolled with a health plan as of December 31, 2021. During the FY 2021–2022, HSAG used

2-6 Network Adequacy Standards, 42 CFR §438.68. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=d748c4b2039bd7ac516211b8a68e5636&mc=true&node=se42.4.438_168&rgn=div8. Accessed on: Oct 24, 2022.

2-7 The federal network adequacy standard lists the following provider categories that represent common types or specialties of healthcare providers generally needed within a Medicaid population: primary care, adult and pediatric; obstetrics/gynecology (OB/GYN); BH (mental health and substance abuse disorder), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

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 CHP+ MCO, which included data values with provider attributes for type (e.g., nurse practitioner), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code. Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid and CHP+ member and network files from the Department for members enrolled with an MCE and practitioners, practices, and entities enrolled in *interChange*.

How Data Were Aggregated and Analyzed

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 2021–2022. 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 analyses using the Quest Analytics Suite Version 2021.3 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.[2-8] 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 provider data and the Department's member data to perform the geoaccess analysis specific to each 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 5.1H 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, 2021. All parents/caretakers of sampled members completed the surveys from February to May 2022. 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

[2-8] 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: Oct 24, 2022.

interviewing (CATI) of parents/caretakers of sampled child members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent at different times of the day, on different days of the week, and in different weeks.

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

HSAG performed a trend analysis of the results in which the FY 2021–2022 scores were compared to their corresponding FY 2020–2021 scores to determine whether there were statistically significant differences. Statistically significant differences between the FY 2021–2022 top-box scores and the FY 2020–2021 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in FY 2021–2022 than FY 2020–2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2021–2022 than FY 2020–2021 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. Given that differences in case-mix can result in differences in ratings between health plans that are not due to differences in quality, the data for the health plans were case-mix adjusted for child member general health status, child member mental health status, respondent education level, and respondent age to account for disparities in these characteristics; therefore, the plan comparison results of the five CHP+ health plans may be different than the trend analysis results. Statistically significant differences between the health plans' and the statewide aggregate top-box scores are noted with arrows. A health plan's top-box score that was statistically significantly higher than the statewide aggregate score is noted with an upward green (↑) arrow. A health plan's top-box score that was statistically significantly lower than the statewide

aggregate score is noted with a downward red (↓) arrow. A health plan's top-box score that was not statistically significantly different than the statewide aggregate score is not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality 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
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

EQR Dashboard

Objectives

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

HSAG developed the following two dashboards:

- **Compare Plans Overall, by Domain, and by Measure**—allows the user to select a program (i.e., CHP+, Medicaid, RAE) and review how all MCEs within the program performed at a high level.
- **Plan Rating Review**—this view provides MCE-level results for all domains, measures, and indicators. This view also includes the ranking information to identify how the selected MCE compares to others in its program and additional insight on areas that may warrant focus.

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

How Conclusions Were Drawn

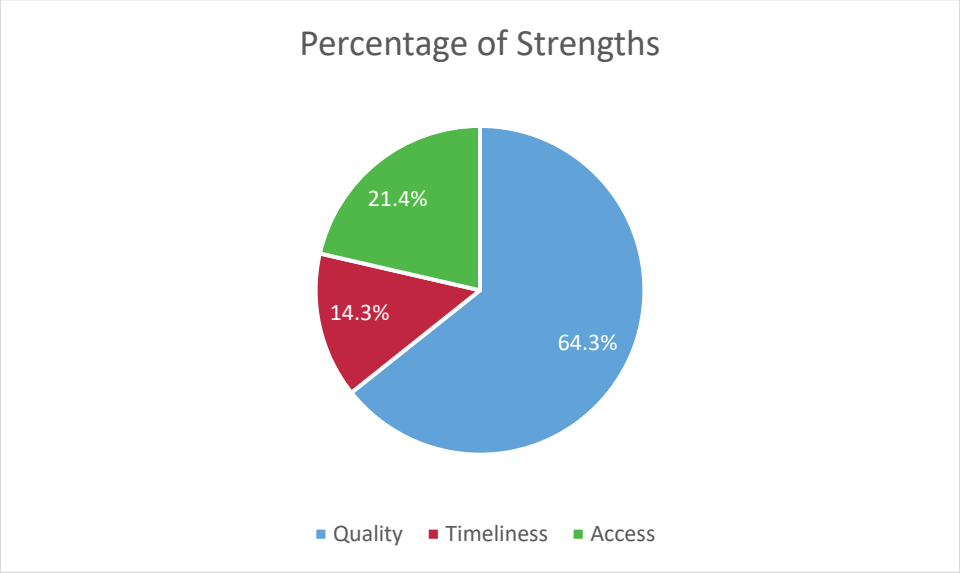
Users may click on an exclamation mark icon in the Plan Rating Review Dashboard that will show an additional interactive screen where the user can select criteria to see a list of low performing measures, which may provide opportunities for improvement or high performing measures. The user can use one or more of the criteria: decrease in performance from year to year, performance relative to NCQA benchmarks, and below the statewide average. The user can also set the threshold to use for each of the criteria. An additional table will populate with measures meeting the selected criteria.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2021–2022. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

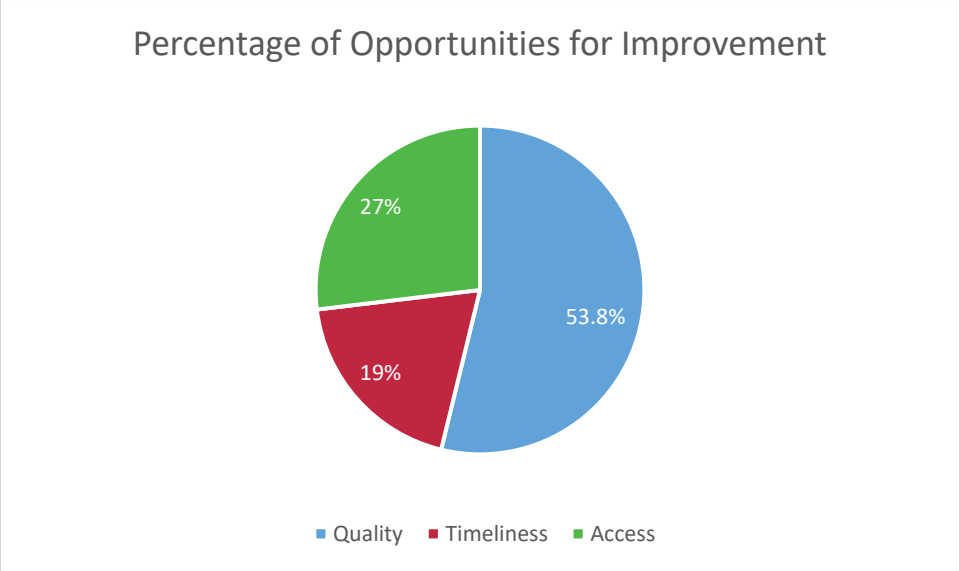
Colorado Access

Figure 3-1—Percentage of Strengths by Care Domain for COA*



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

Figure 3-2—Percentage of Opportunities for Improvement by Care Domain for COA*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

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

Background: FY 2020–2021 PIP Activities

Table 3-1 and Table 3-2 summarize COA's PIP activities that were completed and validated in FY 2020–2021. Table 3-1 provides the SMART Aim statements that COA defined for the two PIP outcome measures in Module 1.

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

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

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

Table 3-2 summarizes the preliminary key drivers and potential interventions COA identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-2—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

FY 2021–2022 PIP Activities

In FY 2021–2022, COA continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, COA developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, COA submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical

assistance, if needed, as COA carried out PDSA cycles to evaluate intervention effectiveness. Table 3-3 presents the FY 2021–2022 Module 3 validation findings for COA's four interventions.

Table 3-3—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

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

[1]*PHQ = Patient Health Questionnaire*

In Module 3, COA selected four interventions to test for the PIP. The interventions addressed process failures in clinic workflows, coding practices, and BH provider availability. For each intervention, COA defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for COA:

- Selecting four interventions to address key drivers and failure modes related to depression screening and follow-up care processes and facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of four interventions and developed a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. COA addressed all Module 3 PIP validation criteria.

To support successful progression of COA's PIP in the next fiscal year, HSAG recommends COA:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to COA's MY 2021 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 performance measure reporting.

Performance Measure Results

Table 3-4 shows the performance measure results for COA for MY 2019 through MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-4—Performance Measure Results for COA

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits[H]				
Total	—	47.69%	48.16%	50th–74th
Childhood Immunization Status[H]				
Combination 3	70.04%	72.50%	**65.97%^^**	25th–49th
Combination 7	59.92%	65.12%	**57.35%^^**	25th–49th
Combination 10	46.78%	53.69%	**46.81%^^**	75th–89th
Chlamydia Screening in Women[H]				
Ages 16 to 20 Years	34.07%	33.74%	34.66%	<10th
Developmental Screening in the First Three Years of Life[CS]				
Total	—	—	—	—
Immunizations for Adolescents[H]				
Combination 1 (Meningococcal, Tdap)	76.14%	76.97%	76.45%	25th–49th
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	40.19%	41.81%	**37.74%^^**	50th–74th
Screening for Depression and Follow-Up Plan[SA]				
Ages 12 to 17 Years	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[H]				
BMI Percentile Documentation—Total	11.78%	15.33%	16.32%	<10th
Counseling for Nutrition—Total	6.66%	10.66%	13.92%^	<10th
Counseling for Physical Activity—Total	4.36%	7.62%	9.37%	<10th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	54.92%	61.19%	50th–74th
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	75.31%	**65.48%^^**	10th–24th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age[SA]				
Total	—	—	—	—
Contraceptive Care—All Women[CS]				
LARC—Ages 15 to 20 Years	—	—	—	—
MMEC—Ages 15 to 20 Years	—	—	—	—
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	—	—
LARC—60 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—3 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—60 Days—Ages 15 to 20 Years	—	—	—	—
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	56.92%	<10th
Care of Acute and Chronic Conditions				
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	75.43%	ACSM
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				
7-Day Follow-Up—Ages 6 to 17 Years	—	—	36.42%	10th–24th
30-Day Follow-Up—Ages 6 to 17 Years	—	—	54.91%	<10th
Follow-Up Care for Children Prescribed ADHD Medication[H]				
Initiation Phase	0.00%	33.78%	29.03%	<10th
Continuation and Maintenance Phase	NA	46.94%	38.60%	10th–24th
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	60.58%	40.80%	50.00%	50th–74th
Cholesterol Testing—Total	33.65%	19.20%	27.19%	25th–49th
Blood Glucose and Cholesterol Testing—Total	30.77%	19.20%	27.19%	25th–49th
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	72.00%	75th–89th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	19.23	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
ACSM indicates the reported rate was above the Core Set Median.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.

COA: Strengths

The following HEDIS MY 2021 measure rate was determined to be a high-performing rate for COA (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2020; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2020):

- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*

The following non-HEDIS MY 2021 Core Set measure rate was determined to be a high-performing rate for COA (i.e., was above the Core Set Median):

- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)*

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

The following HEDIS MY 2021 measure rates were determined to be low-performing rates for COA (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2020):

- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Ages 21 to 24 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years and 30-Day Follow-Up—Ages 6 to 17 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

To address these low rates, HSAG recommends COA:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends COA coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[3-1]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-2]
- For those measures where a follow-up is required, set up reminders for members to ensure the follow-up visit occurs.

[3-1] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 25, 2022.

[3-2] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 25, 2022.

Assessment of Compliance With CHIP Managed Care Regulations

COA Overall Evaluation

Table 3-5 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 2021–2022.

Table 3-5—Summary of COA Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	18	18	17	1	0	0	94%
Totals	**65**	**65**	**64**	**1**	**0**	**0**	**98%**

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

Table 3-6 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 2021–2022.

Table 3-6—Summary of COA Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	87	87	0	13	100%
Recredentialing	90	76	76	0	14	100%
Totals	**190**	**163**	**163**	**0**	**27**	**100%**

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

COA: Trended Performance for Compliance With Regulations

Table 3-7 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 3-7—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—Adequate Capacity and Availability of Services (2016–2017, 2019–2020)	100%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**88%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	95%	88%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	100%	100%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	**89%**	**94%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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.*

In FY 2021–2022, COA maintained 100 percent compliance in two standards: Standard III—Coordination and Continuity of Care and Standard VIII—Credentialing and Recredentialing. COA demonstrated improvements in two other standards, improving from 88 to 100 percent compliance for Standard IV—Member Rights, Protections, and Confidentiality and from 89 to 94 percent for Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. Overall, COA achieved 100 percent compliance for six of the 10 standards reviewed in the most recent compliance review cycle.

COA: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG identified the following strengths for COA:

- COA demonstrated systemwide resources dedicated to coordinating care for CHP+ members, including policies and procedures, multi-disciplinary care teams, and software platforms. The MCO outreached to members within 48 hours of a care coordination referral and reported a 58 percent follow-up success rate on any health risk assessment (HRA) data that indicated additional outreach needs. Across 19 hospitals, COA had care managers on-site and maintained standing relationships with these facilities to identify member support needed and provide efficient referral procedures.
- COA defined members' rights and responsibilities in its policies and procedures, provider manual, company website, training, member handbook, bulletins, member portal, and notice of privacy practices; and reinforced confidentiality through training.
- All sample records aligned with NCQA guidelines. COA's credentialing committee reduced initial application processing time frames from an average of 22 days to 20 days in CY 2021 and reported that annual delegation monitoring met the COA-required 95 percent compliance rate for the audit.
- COA's documents described a comprehensive, ongoing QAPI program with established governance and oversight, committees and workgroups, objectives, and a detailed evaluation of performance. COA adopted and disseminated clinical practice guidelines (CPGs) and reviewed resources regularly to ensure CPGs remained relevant and up to date. Lastly, COA demonstrated key initiatives for detecting over- and underutilization.

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

HSAG found the following opportunities for improvement:

- Following outreach calls from care coordinators, COA did not send follow-up letters with detailed information including services discussed over the phone with the member.
- COA's *Member Disability Rights Request and Complaint Resolution* policy did not accurately state that if a member submits a complaint, COA must resolve the grievance within the state-required time frames and staff members may assist the member in submitting a complaint with the Office of Civil Rights.
- COA was unable to demonstrate within its policies or procedures an annual retrospective review of denied providers to verify that the provider was not denied based on discriminatory reasons.
- COA reported that it did not collect any information related to disenrollment for reasons other than loss of eligibility.

To address these opportunities for improvement, HSAG recommends COA:

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

Validation of Network Adequacy

COA: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for COA:

- While COA did not meet all minimum time and distance network requirements across all counties in each county designation, their behavior health and primary care networks were their top performing networks. The General BH, Adult Primary Care Practitioners (MD, DO, NP, CNS), and Adult Primary Care Practitioners (PA) networks met all minimum standards across all contracted counties; and Pediatric BH, Family Practitioners, and Pediatric Practitioners (MD, DO, NP, CNS) failed to meet the standard in only two out of 44 counties. 

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

HSAG found the following opportunities for improvement:

- COA did not meet the minimum time and distance network requirements for Pediatric Specialists, Pharmacies, and Acute Care Hospitals across multiple contracted counties. 

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

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

Findings

Table 3-8 shows the results achieved by COA for FY 2019–2020 through FY 2021–2022.

Table 3-8—Top-Box Scores for COA

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	62.4%	66.4%	68.5%
Rating of All Health Care	69.5%	72.8%	65.7%
Rating of Personal Doctor	78.2%	78.1%	75.4%
Rating of Specialist Seen Most Often	73.8%+	67.1%+	62.0%+
Getting Needed Care	83.8%	78.9%	83.3%
Getting Care Quickly	91.1%	85.7%	83.6%
How Well Doctors Communicate	97.7%	93.0%	97.4% ▲
Customer Service	79.9%+	87.4%+	92.5%+

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

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

COA: Strengths

COA scored statistically significantly higher in FY 2021–2022 than in FY 2020–2021 on the following measure:

- *How Well Doctors Communicate*

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

The following measures' scores for COA showed a downward trend over the three-year period:

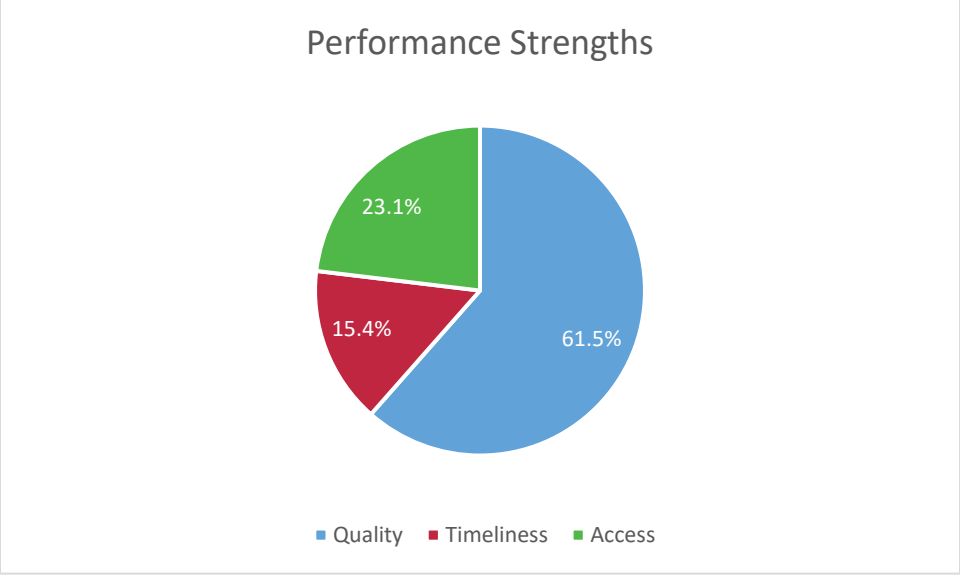
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Care Quickly*

To address these low CAHPS scores, HSAG recommends COA:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they receive. The results may help to determine what could be driving lower scores compared to the previous years. COA should implement appropriate interventions to improve the performance related to members' perceptions about the care members need.
- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes that may be contributing to lower experience scores across years for *Rating of Personal Doctor* and develop initiatives designed to improve performance such as:
  - Enhancing provider informational materials.
  - Exploring providers' ability to communicate effectively with members.

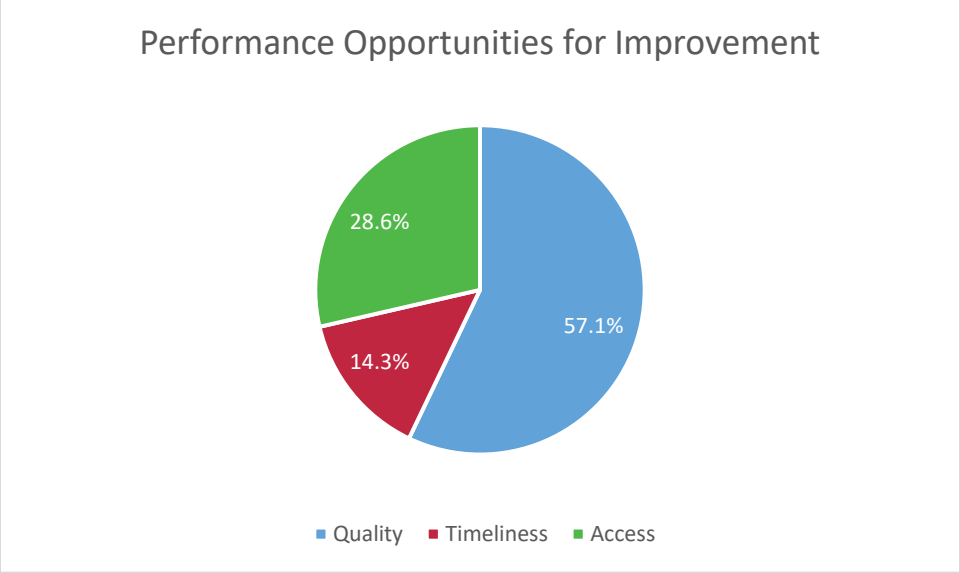
Denver Health Medical Plan, Inc.

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



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

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



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

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

Key:

- Quality = 
- Timeliness = 
- Access = 

Validation of Performance Improvement Projects

Validation Activities and Interventions

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

Background: FY 2020–2021 PIP Activities

Table 3-9 and Table 3-10 display summarize DHMP's PIP activities that were completed and validated in FY 2020–2021. Table 3-9 provides the SMART Aim statements that DHMP defined for the two PIP outcome measures in Module 1.

Table 3-9—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

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

Table 3-10 summarizes the preliminary key drivers and potential interventions DHMP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-10—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

FY 2021–2022 PIP Activities

In FY 2021–2022, DHMP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, DHMP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, DHMP submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as DHMP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-11 presents the FY 2021–2022 Module 3 validation findings for DHMP's two interventions.

Table 3-11—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

In Module 3, DHMP selected two interventions to test for the PIP. The interventions addressed process failures related to appointment attendance and access to services. For each intervention, DHMP defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- Selecting two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. DHMP addressed all Module 3 PIP validation criteria.

To support successful progression of DHMP's PIP in the next fiscal year, HSAG recommends DHMP:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to DHMP's MY 2021 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 performance measure reporting.

Performance Measure Results

Table 3-12 shows the performance measure results for DHMP for MY 2019 through MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-12—Performance Measure Results for DHMP

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
***Child and Adolescent Well-Care Visits**[H]*				
Total	—	46.11%	47.87%	50th–74th
***Childhood Immunization Status**[H]*				
Combination 3	82.26%	81.94%	**52.00%^^**	<10th
Combination 7	79.03%	75.00%	**48.00%^^**	10th–24th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Combination 10	58.06%	63.89%	**44.00%^^**	50th–74th
Chlamydia Screening in Women[H]				
Ages 16 to 20 Years	47.89%	44.29%	38.33%	10th–24th
Developmental Screening in the First Three Years of Life[CS]				
Total	—	—	—	—
Immunizations for Adolescents[H]				
Combination 1 (Meningococcal, Tdap)	86.71%	88.00%	**64.97%^^**	<10th
Combination 2 (Meningococcal, Tdap, HPV)	53.80%	54.00%	**42.94%^^**	50th–74th
Screening for Depression and Follow-Up Plan[SA]				
Ages 12 to 17 Years	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[H]				
BMI Percentile Documentation—Total	23.81%	63.96%	72.47%^	25th–49th
Counseling for Nutrition—Total	8.31%	70.36%	77.72%^	75th–89th
Counseling for Physical Activity—Total	7.41%	69.92%	77.33%^	75th–89th
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	64.52%	50.00%	25th–49th
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	66.18%	63.29%	10th–24th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age[SA]				
Total	—	—	—	—
Contraceptive Care—All Women[CS]				
LARC—Ages 15 to 20 Years	—	—	—	—
MMEC—Ages 15 to 20 Years	—	—	—	—
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	—	—
LARC—60 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—3 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—60 Days—Ages 15 to 20 Years	—	—	—	—
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	NA	—
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
7-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[H]				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	NA	—
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	13.31	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.

DHMP: Strengths

The following HEDIS MY 2021 measure rates were determined to be high-performing rates for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2020; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2020):

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

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

The following HEDIS MY 2021 measure rates were determined to be low-performing rates for DHMP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2020):

- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

To address these low rates, HSAG recommends DHMP:

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

[3-3] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 25, 2022.

[3-4] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 25, 2022.

Assessment of Compliance With CHIP Managed Care Regulations

DHMP Overall Evaluation

Table 3-13 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2021–2022.

Table 3-13—Summary of DHMP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	32	31	1	0	0	97%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	18	18	18	0	0	0	100%
Totals	**65**	**65**	**64**	**1**	**0**	**0**	**98%**

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

Table 3-14 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2021–2022.

Table 3-14—Summary of DHMP Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	90	90	0	10	100%
Recredentialing	90	82	82	0	8	100%
Totals	**190**	**172**	**172**	**0**	**18**	**100%**

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

DHMP: Trended Performance for Compliance With Regulations

Table 3-15 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 3-15—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—Adequate Capacity and Availability of Services (2016–2017, 2019–2020)	92%	88%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**60%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	83%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	91%	94%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	79%	93%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**100%**	**97%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	**89%**	**100%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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.*

In FY 2021–2022, DHMP maintained 100 percent compliance in one standard: Standard IV—Member Rights, Protections, and Confidentiality. DHMP reached 100 percent compliance for two standards: Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. DHMP's compliance scores declined by 3 percentage points for one standard: Standard VIII—Credentialing and Recredentialing (from 100 to 97 percent). Overall, during the past two review cycles DHMP improved in six of the 10 standards, with the most notable improvement in Standard III—Coordination and Continuity of Care (from 60 to 100 percent).

DHMP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for DHMP:

- DHMP informed members about how to contact their primary healthcare providers and made efforts to assess member healthcare needs within the first 90 days after enrollment, including following up with a telephone survey if the mailed assessment is unsuccessful.
- DHMP's policies and procedures clearly defined members with special health care needs (SHCN). Staff members described frequent internal meetings to reduce duplication of care coordination activities and EHR capabilities to send out a system-wide message to the treatment team.
- DHMP's credentialing and recredentialing processes and sample records demonstrated compliance with NCQA standards. DHMP described delegate audits and reported no corrective action plans (CAPs) in CY 2021.
- DHMP redistributed the Quality Management Committee (QMC) voting membership during the review period to ensure that the voting structure reflected equal input from key departments across DHMP. HSAG recognized this approach as a best practice for monitoring member services and oversight of quality activities. DHMP described the mechanism implemented to track and report disenrollment for reasons other than loss of Medicaid eligibility.

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

HSAG found the following opportunities for improvement:

- DHMP did not demonstrate an annual retrospective review of denied providers to verify that the denial was not based on discriminatory reasons.
- DHMP did not include 16 of the 20 practitioners from the record review sample in the online CHP+ provider directory.
- One organizational provider sample record demonstrated a four-month gap between the date of credentialing staff validation and medical director approval. Although DHMP checked for quality of care concerns (QOCCs) in the file in January 2021, the file did not receive final approval until September 2021.

To address these opportunities for improvement, HSAG recommends DHMP:

- Include in its policy or procedure an annual process to retrospectively review declined provider data to validate that the process of redacting demographic identifiers proved sufficient to ensure that declined providers were not declined based on discrimination.

- Expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.
- Review internal procedures for handling credentialing data and ensure accuracy when staff verification and medical director approval occur. DHMP should consider timely monitoring of quality issues and complaints.

Validation of Network Adequacy

DHMP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for DHMP:

- DHMP networks met the minimum time and distance network requirements for General BH, General Specialties and Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS), Adult and Pediatric Primary Care Practitioners (PA), and Gynecology OB/GYN (MD, DO, NP, CNS) across all contracted counties. 

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

HSAG found the following opportunities for improvement:

- DHMP did not meet the minimum time and distance network requirements for Acute Care Hospitals and Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals for any of its contracted counties. Pediatric Specialists did not meet the minimum time and distance network requirements across many of its contracted counties. 

To address these opportunities for improvement, HSAG recommends DHMP:

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

Findings

Table 3-16 shows the results achieved by DHMP for FY 2019–2020 through FY 2021–2022.

Table 3-16—Top-Box Scores for DHMP

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	65.0%	70.9%	65.8%
Rating of All Health Care	66.5%	76.5%	66.1%
Rating of Personal Doctor	85.1%	82.8%	78.4%
Rating of Specialist Seen Most Often	77.1%+	71.2%+	66.7%+
Getting Needed Care	80.5%	83.4%	68.2%+ ▼
Getting Care Quickly	85.9%	86.2%	77.2%+ ▼
How Well Doctors Communicate	96.9%	94.9%	93.8%+
Customer Service	86.1%+	87.0%	82.4%+

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

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

DHMP: Strengths

DHMP did not score statistically significantly higher in FY 2021–2022 than in FY 2020–2021, nor did DHMP show an upward score trend over the three-year period on any of the measures.

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

DHMP scored statistically significantly lower in FY 2021–2022 than in FY 2020–2021 on the following measures:

- *Getting Needed Care*
- *Getting Care Quickly*

To address these low CAHPS scores, HSAG recommends DHMP:

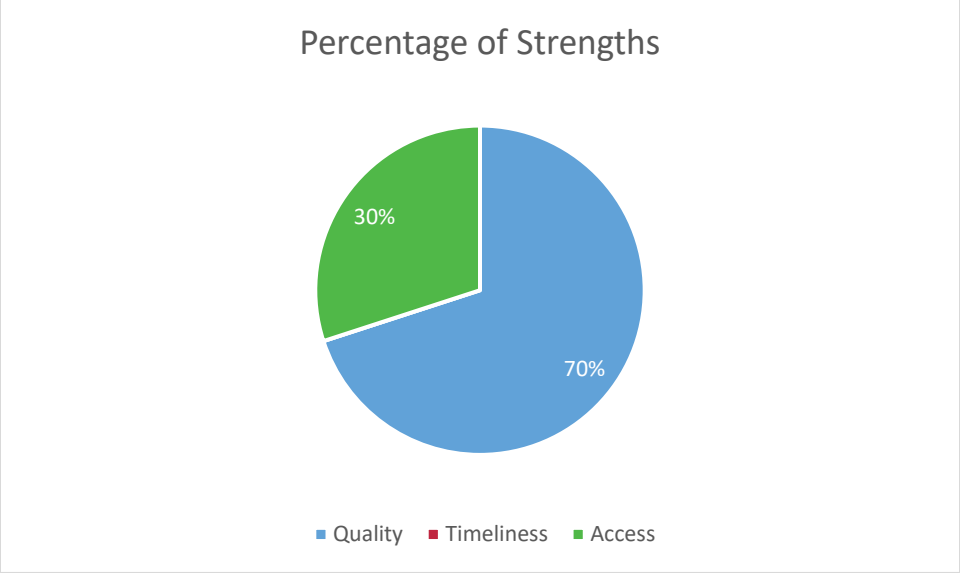
- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they receive. The results may help to determine what could be driving lower scores compared to the previous years. DHMP should implement appropriate

interventions to improve the performance related to members' perceptions about the care members need.

- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

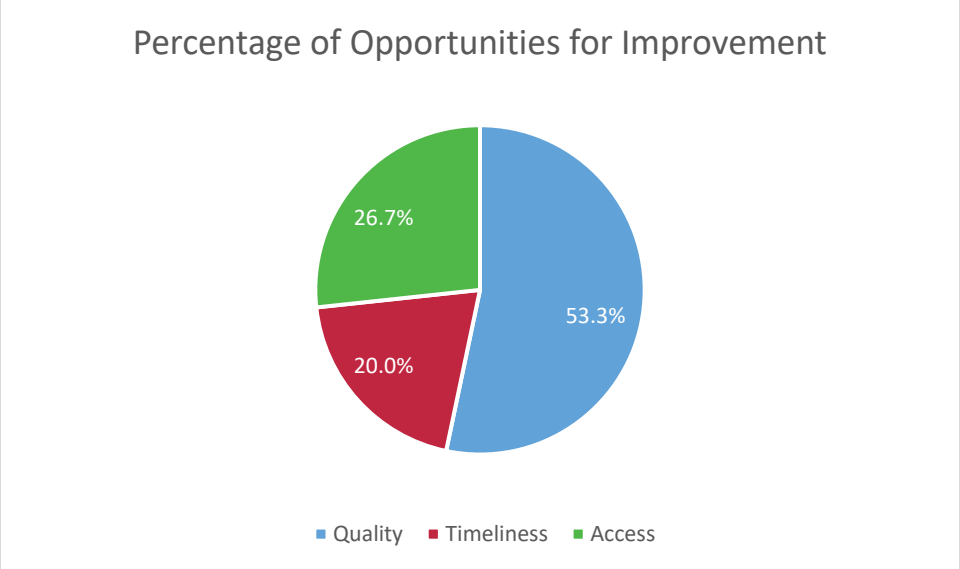
Friday Health Plans of Colorado[3-5]

Figure 3-5—Percentage of Strengths by Care Domain for FHP*



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

Figure 3-6—Percentage of Opportunities for Improvement by Care Domain for FHP*



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

[3-5] FHP's contract with the Department ended on June 30, 2022.

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

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

Background: FY 2020–2021 PIP Activities

Table 3-17 and Table 3-18 summarize FHP's PIP activities that were completed and validated in FY 2020–2021. Table 3-17 provides the SMART Aim statements that FHP defined for the two PIP outcome measures in Module 1.

Table 3-17—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, 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.

Table 3-18 summarizes the preliminary key drivers and potential interventions FHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-18—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
Preliminary Key Drivers	• Provider engagement in proper coding for depression screening services. • Consistent depression screening coding practices among providers and staff.
Potential Interventions	• Provider and staff education on proper coding and offer ideas for process improvement efforts. • Member/caregiver education on the clinical importance of depression screening for adolescent members during outpatient visits. • Develop educational tools for providers and staff. • Develop information packet for child and caregiver that includes contact information for BH services.
Measure 2—*Follow-Up After a Positive Depression Screen*	
Preliminary Key Drivers	• Provider support in capturing depression screening and follow-up services through appropriate coding practices. • Periodic record reviews to ensure that providers' offices are entering appropriate depression screening and follow-up codes. • Consistent use of G8431 as documentation of the depression screening and follow-up plan.
Potential Interventions	• Provider education on correct depression screening codes (G8431 and G8510) and why it is important to have those codes on the claims. • Develop education tools for providers and their staff. • Develop a tracking tool to monitor members who participate in follow-up BH services.

FY 2021–2022 PIP Activities

In FY 2021–2022, FHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, FHP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, FHP submitted a testing plan for one intervention. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as FHP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-19 presents the FY 2021–2022 Module 3 validation findings for FHP's intervention.

Table 3-19—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Provider and staff educational email describing appropriate codes to capture depression screening and follow-up BH services, and questionnaire on provider's current depression screening and follow-up process	• Provider does not enter the billing code or enters an incorrect code	• Provider engagement in proper coding for depression screening services • Consistent depression screening coding practices among providers and staff • Provider support in capturing depression screening and follow-up services through appropriate coding practices	• Percentage of members 12–17 years of age who had an outpatient visit and received a depression screening during the visit • Percentage of providers who were sent the educational email and opened/read the email • Percentage of providers who were sent the educational email and returned the depression screening and follow-up workflow questionnaire

In Module 3, FHP selected one intervention to test for the PIP. The intervention addressed process failures in provider awareness and consistent use of appropriate coding practices for depression screening and follow-up services. For the intervention, DHMP defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for FHP:

- Selecting an intervention to address key drivers and failure modes related to depression screening and follow-up care processes and facilitate achievement of the SMART Aim goals for improvement.

- Initiated intervention testing and developed a methodologically sound plan for evaluating effectiveness of the intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. FHP addressed all Module 3 PIP validation criteria.

To support successful progression of FHP's PIP in the next fiscal year, HSAG recommended FHP:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to FHP's MY 2021 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 performance measure reporting.

Performance Measure Results

Table 3-20 shows the performance measure results for FHP for MY 2019 through MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-20—Performance Measure Results for FHP

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
***Child and Adolescent Well-Care Visits**[H]*				
Total	—	32.50%	**0.00%^^**	<10th
***Childhood Immunization Status**[H]*				
Combination 3	0.00%	NA	NA	—
Combination 7	0.00%	NA	NA	—
Combination 10	0.00%	NA	NA	—
***Chlamydia Screening in Women**[H]*				
Ages 16 to 20 Years	NA	NA	NA	—
***Developmental Screening in the First Three Years of Life**[CS]*				
Total	—	—	—	—
***Immunizations for Adolescents**[H]*				
Combination 1 (Meningococcal, Tdap)	41.94%	43.40%	**0.00%^^**	<10th
Combination 2 (Meningococcal, Tdap, HPV)	8.06%	22.64%	**0.00%^^**	<10th
***Screening for Depression and Follow-Up Plan**[SA]*				
Ages 12 to 17 Years	—	—	—	—
***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**[H]*				
BMI Percentile Documentation—Total	13.69%	6.18%	NA	—
Counseling for Nutrition—Total	5.38%	2.56%	NA	—
Counseling for Physical Activity—Total	1.96%	3.62%	NA	—

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	NA	NA	—
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	NA	19.35%	<10th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age[SA]				
Total	—	—	—	—
Contraceptive Care—All Women[CS]				
LARC—Ages 15 to 20 Years	—	—	—	—
MMEC—Ages 15 to 20 Years	—	—	—	—
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	—	—
LARC—60 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—3 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—60 Days—Ages 15 to 20 Years	—	—	—	—
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	NA	—
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				
7-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[H]				
Initiation Phase	—	—	—	—
Continuation and Maintenance Phase	—	—	—	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	NA	—

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	NA	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.

FHP: Strengths

None of the MY 2021 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 MY 2020; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2020).

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

The following HEDIS MY 2021 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 MY 2020):

- *Child and Adolescent Well-Care Visits—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

To address these low rates, HSAG recommended FHP:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommended FHP coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[3-6]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-7]

Assessment of Compliance With CHIP Managed Care Regulations

FHP Overall Evaluation

Table 3-21 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 2021–2022.

Table 3-21—Summary of FHP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	5	5	0	0	50%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	4	1	0	0	80%
Standard VIII—Credentialing and Recredentialing	32	31	24	7	0	1	77%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	18	18	12	6	0	0	67%
Totals	**65**	**64**	**45**	**19**	**0**	**1**	**70%**

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

[3-6] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 25, 2022.

[3-7] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 25, 2022.

Table 3-22 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 2021–2022.

Table 3-22—Summary of FHP Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	85	84	1	15	99%
Recredentialing	54	53	51	2	1	96%
Totals	**154**	**138**	**135**	**3**	**16**	**98%**

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

FHP: Trended Performance for Compliance With Regulations

Table 3-23 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 3-23—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—Adequate Capacity and Availability of Services (2016–2017, 2019–2020)	79%	81%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**78%**	**50%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**88%**	**80%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	92%	67%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	82%	53%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	93%	75%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**86%**	**77%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	50%

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	**83%**	**67%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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.*

In FY 2021–2022, FHP's compliance scores declined in comparison to previous review cycles across all four standards reviewed, with the lowest score and largest decrease in Standard III—Coordination and Continuity of Care (from 78 to 50 percent, a 28 percentage point decrease), followed by Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (from 83 to 67 percent, a 16 percentage point decrease); Standard VIII—Credentialing and Recredentialing (from 86 to 77 percent, a 9 percentage point decrease); and Standard IV—Member Rights, Protections, and Confidentiality (from 88 to 80 percent, a 8 percentage point decrease). Among other standards reviewed in previous cycles, only one of the 10 standards reviewed showed improvement from the previous review cycle, Standard II—Adequate Capacity and Availability of Services.

FHP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for FHP:

- FHP described targeting low needs members to receive occasional outreach, while high needs members who required more frequent monitoring received support exclusively from registered nurses.
- FHP's documents outlined expectations for protecting member rights and privacy, including a zero-tolerance policy about retaliation against members for exercising their rights.
- FHP's policies and procedures focused on ensuring providers' compliance with NCQA and URAC standards and guidelines.
- FHP's QAPI program contained the core elements, such as a Quality Management Program Committee (QMPC), which reviewed quality reports, initiatives, and provided oversight of policies and procedures. The program included monitoring measures, such as HEDIS, well-child visits, and expansion of telehealth visits.

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

HSAG found the following opportunities for improvement:

- FHP did not adequately outline in its policies and procedures detailed steps related to delivering and documenting care coordination services for its members (e.g., time frames for completing the HRA or procedures to follow should additional needs be identified by the HRA). FHP did not utilize a structured welcome script or similar approach to inform members how to contact their case manager, and procedures did not include details regarding treatment plan updates or clinical reassessments.
- FHP's documents did not contain the full list of member rights and responsibilities. Although FHP described monitoring for member rights issues through grievances, FHP did not record any grievances in the last few years.
- FHP did not include key details regarding a CMS or State quality review in lieu of accreditation in the Credentialing Plan, and staff members were not able to speak to the annual delegation monitoring procedures.
- FHP's credentialing data indicated approval dates that were inconsistent with the actual medical director or Physician Advisory Committee (PAC) approval; the credentialing file universe included inaccurate recredentialing dates and many terminated providers within the data. Two sample files lacked evidence of medical director or PAC credentialing approval; one sample file did not have the associated education, training, and licensure required by the State of Colorado; one organizational provider file was not recredentialed within the 36-month time frame; and FHP did not have a mechanism to track and trend details regarding escalating quality-related organizational provider issues.
- FHP's QAPI program did not integrate available data, review successes and barriers regularly, or ensure follow-up procedures to act on issues when identified. In addition, FHP did not submit evidence regarding an annual impact evaluation of the Quality Assurance Plan (QAP).
- FHP did not have a mechanism within its QAPI program to assess the quality and appropriateness of care for members with SHCN and disseminate practice guidelines to providers. Other than CAHPS data, FHP did not report monitoring regarding members' perceptions of the accessibility and adequacy of services. FHP did not have a mechanism to detect underutilization of services; identify, track, and trend QOC issues; and identify individual care concerns.

To address these opportunities for improvement, HSAG recommended FHP:

- Revise care coordination policies to include all requirements (timely coordination or services, monitoring of course of treatment, reassessment every 12 months), outline key steps in coordinating care between care settings, and ensure processes are implemented and documented. FHP should provide each member with information on how to contact their case manager, make its best effort to

collect HRA information within 90 days, and develop mechanisms to identify and follow-up with any member identified with a SCHN within appropriate time frames.

- Develop a concise policy that includes all member rights and consider additional staff trainings.
- Enhance credentialing procedures to report the approval date in the system accurately and separately from when recredentialing efforts begin; monitor delegates annually per Colorado standards; and develop a system to follow up on opportunities for improvement, when applicable.
- Expand procedural details to include expectations for practitioners regarding associated education, training, and licensure required by the State of Colorado; develop a process to ensure the PAC committee monitors quality-related organizational provider issues; update policies to reflect current practices regarding on-site quality assessment for organizational providers; and enhance monitoring mechanisms to ensure organizational providers are recredentialed every 36 months.
- Develop a more robust QAPI program that integrates available data, reviews successes and barriers, and ensures follow-up procedures to act on issues when identified; and expand current processes to ensure annual evaluation of the QAPI program and the integration of the work plan and annual program review worksheet into the FHP QAP for tracking and trending to assess successes and barriers periodically.
- Utilize other sources of member feedback in addition to the CAHPS survey to analyze and build well-rounded member feedback regarding access and adequacy of services; develop a mechanism to detect underutilization of services; identify, track, and trend QOC issues and identify individual care concerns; and implement a mechanism to periodically assess the quality and appropriateness of care furnished to members with SHCN.

Validation of Network Adequacy

FHP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for FHP:

- FHP met all minimum time and distance standard requirements for Pediatric and Family Primary Care Practitioners (MD, DO, NP, and CNS) across all contracted counties.

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

HSAG found the following opportunities for improvement:

- FHP did not meet the minimum time and distance network requirements for Pharmacies and Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals and Pediatric Specialties across multiple contracted counties.

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

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

Findings

Table 3-24 shows the results achieved by FHP for FY 2019–2020 through FY 2021–2022.

Table 3-24—Top-Box Scores for FHP

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	59.1%	63.8%	59.6%
Rating of All Health Care	59.8%+	58.6%+	54.1%+
Rating of Personal Doctor	74.5%	63.9%	64.7%
Rating of Specialist Seen Most Often	77.8%+	70.0%+	75.0%+
Getting Needed Care	81.9%+	83.2%+	85.4%+
Getting Care Quickly	94.1%+	87.8%+	90.4%+
How Well Doctors Communicate	99.0%+	98.7%+	91.3%+ ▼
Customer Service	97.5%+	88.4%+	79.2%+

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

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

FHP: Strengths

The following measure for FHP showed an upward score trend over the three-year period:

- *Getting Needed Care*

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

FHP scored statistically significantly lower in FY 2021–2022 than in FY 2020–2021 on the following measure:

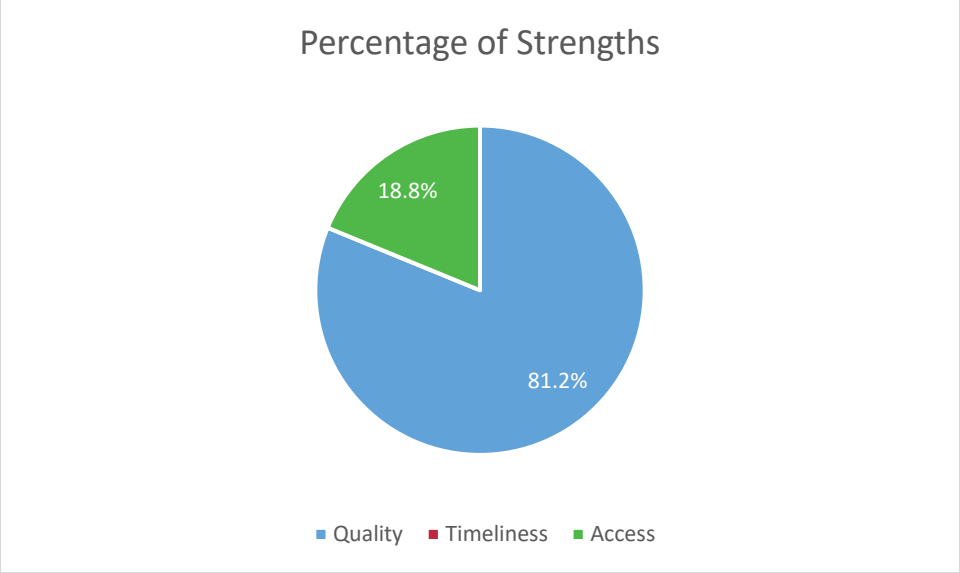
- *How Well Doctors Communicate*

To address this low CAHPS score, HSAG recommended FHP:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they receive. The results may help to determine what could be driving lower scores compared to the previous years. FHP should implement appropriate interventions to improve the performance related to members' perceptions about the care members need.
- Consider if there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Explore provider processes and develop initiatives designed to improve performance, including communications programs for providers or member care reminders to encourage timely requests for services.

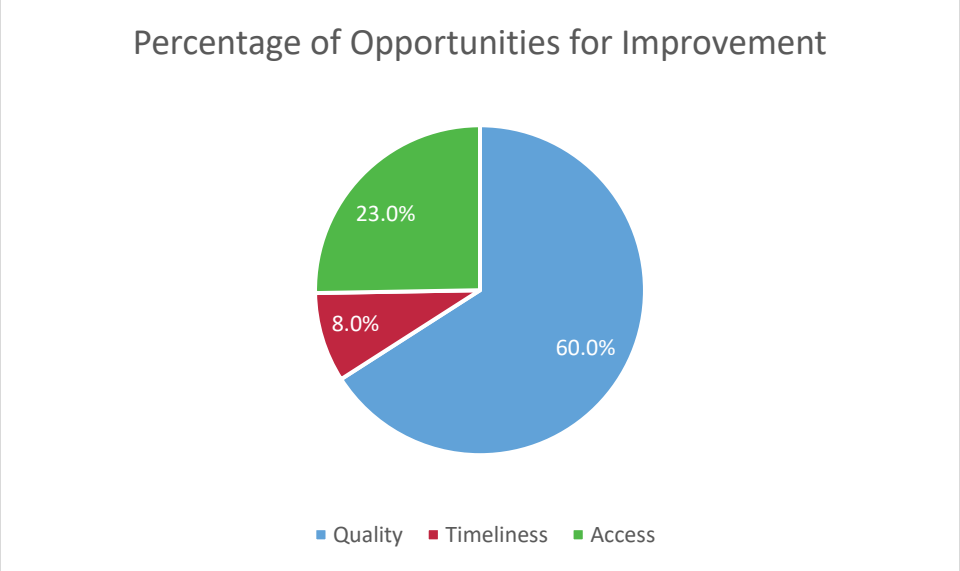
Kaiser Permanente Colorado

Figure 3-7—Percentage of Strengths by Care Domain for Kaiser*



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

Figure 3-8—Percentage of Opportunities for Improvement by Care Domain for Kaiser*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

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

Background: FY 2020–2021 PIP Activities

Table 3-25 and Table 3-26 summarize Kaiser's PIP activities that were completed and validated in FY 2020–2021. Table 3-25 provides the SMART Aim statements that Kaiser defined for the two PIP outcome measures in Module 1.

Table 3-25—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood 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.

Table 3-26 summarizes the preliminary key drivers and potential interventions Kaiser identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-26—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

FY 2021–2022 PIP Activities

In FY 2021–2022, Kaiser continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, Kaiser developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, Kaiser submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as Kaiser carried out PDSA cycles to evaluate intervention effectiveness. Table 3-27 presents the FY 2021–2022 Module 3 validation findings for Kaiser's two interventions.

Table 3-27—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

In Module 3, Kaiser selected two interventions to test for the PIP. The interventions addressed process failures related to consistently delivering the depression screening questionnaire and consistently capturing screening results in the EHR. For each intervention, Kaiser defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for Kaiser:

- Selecting two interventions to address key drivers and failure modes related to depression screening and follow-up care processes and facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. Kaiser addressed all Module 3 PIP validation criteria.

To support successful progression of Kaiser's PIP in the next fiscal year, HSAG recommends Kaiser:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to Kaiser's MY 2021 Compliance Audit Report, Kaiser was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted Kaiser's performance measure reporting.

Performance Measure Results

Table 3-28 shows the performance measure results for Kaiser for MY 2019 through MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-28—Performance Measure Results for Kaiser

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits [H]				
Total	—	34.60%	44.27%^	25th–49th
Childhood Immunization Status [H]				
Combination 3	74.33%	67.50%	77.06%	75th–89th
Combination 7	69.52%	63.75%	69.72%	≥90th
Combination 10	56.15%	49.38%	56.88%	≥90th
Chlamydia Screening in Women [H]				
Ages 16 to 20 Years	52.69%	45.83%	47.12%	25th–49th
Developmental Screening in the First Three Years of Life [CS]				
Total	—	—	—	—
Immunizations for Adolescents [H]				
Combination 1 (Meningococcal, Tdap)	82.33%	85.81%	80.12%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	53.67%	59.46%	**42.47%^^**	50th–74th
Screening for Depression and Follow-Up Plan [SA]				
Ages 12 to 17 Years	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents [H]				
BMI Percentile Documentation—Total	98.04%	93.52%	90.75%	≥90th
Counseling for Nutrition—Total	95.14%	89.31%	92.77%^	≥90th
Counseling for Physical Activity—Total	95.14%	89.31%	93.12%^	≥90th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	51.35%	**16.67%^^**	<10th
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	61.18%	**47.55%^^**	<10th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age[SA]				
Total	—	—	—	—
Contraceptive Care—All Women[CS]				
LARC—Ages 15 to 20 Years	—	—	—	—
MMEC—Ages 15 to 20 Years	—	—	—	—
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	—	—
LARC—60 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—3 Days—Ages 15 to 20 Years	—	—	—	—
MMEC—60 Days—Ages 15 to 20 Years	—	—	—	—
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	91.18%	ACSM
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				
7-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
30-Day Follow-Up—Ages 6 to 17 Years	—	—	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[H]				
Initiation Phase	NA	NA	37.14%	10th–24th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	NA	—

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	—	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
ACSM indicates the reported rate was above the Core Set Median.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.

Kaiser: Strengths

The following HEDIS MY 2021 measure rates were determined to be high-performing rates for Kaiser (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2020; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2020):

- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

The following non-HEDIS MY 2021 Core Set measure rate was determined to be a high-performing rate for Kaiser (i.e., was above the Core Set Median):

- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)*

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

The following HEDIS MY 2021 measure rates were determined to be low-performing rates for Kaiser (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2020):

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

To address these low rates, HSAG recommends Kaiser:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends Kaiser coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[3-8]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-9]

Assessment of Compliance With CHIP Managed Care Regulations

Kaiser Overall Evaluation

Table 3-29 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 2021–2022.

Table 3-29—Summary of Kaiser Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	3	1	1	0	60%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	18	18	18	0	0	0	100%
Totals	**65**	**65**	**63**	**1**	**1**	**0**	**97%**

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

[3-8] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 24, 2022.

[3-9] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 24, 2022.

Table 3-30 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 2021–2022.

Table 3-30—Summary of Kaiser Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	90	90	0	10	100%
Recredentialing	90	83	83	0	7	100%
Totals	**190**	**173**	**173**	**0**	**17**	**100%**

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

Kaiser: Trended Performance for Compliance With Regulations

Table 3-31 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 3-31—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—Adequate Capacity and Availability of Services (2016–2017, 2019–2020)	93%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**80%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**88%**	**60%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	90%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	68%	70%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	87%	100%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%

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

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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.*

In FY 2021–2022, Kaiser maintained 100 percent compliance in one standard: Standard VIII—Credentialing and Recredentialing. Kaiser reached 100 percent compliance in two standards: Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems. However, Kaiser's compliance declined by 28 percentage points for Standard IV—Member Rights, Protections, and Confidentiality (from 88 to 60 percent). Overall, when compared to the review cycles, six of the 10 standards showed improvement or maintained 100 percent compliance.

Kaiser: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for Kaiser:

- Kaiser staff members described a referral system redesign and enhanced registries to help simplify administrative work and reduce barriers to care.
- Kaiser recently hired a civil rights coordinator to oversee compliance with federal and State civil rights laws, and further addressed member rights and discussed a "Belong at KP" training that focuses on non-discrimination.
- Kaiser used "machine learning" internet-based programs to monitor the online provider directory for data accuracy.
- Kaiser reviewed any practitioners who were denied during the credentialing process to ensure that no discrimination occurred during the process, and audited contracted providers by placing randomized phone calls to five offices to test the provider's knowledge of the provider's network participation with Kaiser.
- Kaiser prioritized projects to include SDOH screenings, PIPs, and COVID-19 vaccination efforts.
- Kaiser reviewed, developed, approved, and updated CPGs regularly; stored this information in Kaiser's clinical library; and exported its data warehouse into Microsoft Business Intelligence dashboards, which provided what staff members described to be a usable medium of visualizing key trends.

- The claims processing workflow addressed how automated software identified any issues, such as data formatting or high-cost claims.

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

HSAG found the following opportunities for improvement:

- Kaiser did not have a current policy regarding member rights and its policies, procedures, and other supporting documentation did not include all required details regarding member rights.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Develop or update a historical policy that is inclusive of all member rights.

Validation of Network Adequacy

Kaiser: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for Kaiser:

- Kaiser met all the minimum time and distance network requirements for Adult, Family and Pediatric Primary Care Practitioners (MD, DO, NP and CNS), General BH, General Psychiatrists, and General Substance Use Disorder (SUD) Treatment Providers.

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

HSAG found the following opportunities for improvement:

- Kaiser did not meet the minimum time and distance network requirements for pharmacies for any of its contracted counties. Acute Care Hospitals, Psychiatric Hospitals, and Psychiatric Units in Acute Care Hospitals and Pediatric Specialties did not meet the minimum time distance network requirements across multiple contracted counties.

To address these opportunities for improvement, HSAG recommends Kaiser:

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

Findings

Table 3-32 shows the results achieved by Kaiser for FY 2019–2020 through FY 2021–2022.

Table 3-32—Top-Box Scores for Kaiser

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	61.8%	65.2%	60.6%
Rating of All Health Care	71.3%	70.9%	68.3%
Rating of Personal Doctor	78.1%	76.9%	78.0%
Rating of Specialist Seen Most Often	62.5%+	78.8%+	69.4%+
Getting Needed Care	83.6%	78.7%	79.7%+
Getting Care Quickly	86.4%	88.1%+	80.4%+
How Well Doctors Communicate	96.3%	95.3%	97.8%
Customer Service	89.3%+	83.6%+	85.2%+

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

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*
▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

Kaiser: Strengths

Kaiser did not score statistically significantly higher in FY 2021–2022 than in FY 2020–2021, nor did Kaiser show an upward score trend over the three-year period on any of the measures.

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

The following measure for Kaiser showed a downward score trend over the three-year period:

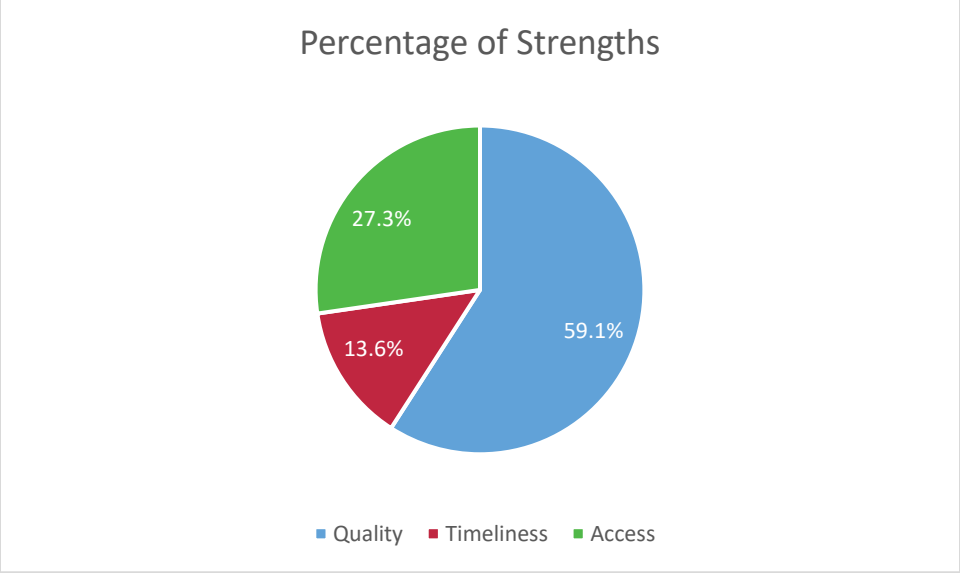
- *Rating of All Health Care*

To address this low CAHPS score, HSAG recommends Kaiser:

- Conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality and timeliness of care and services they receive. The results may help to determine what could be driving lower scores compared to the previous years. Kaiser should implement appropriate interventions to improve the performance related to members' perceptions about the care members need.
- Consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

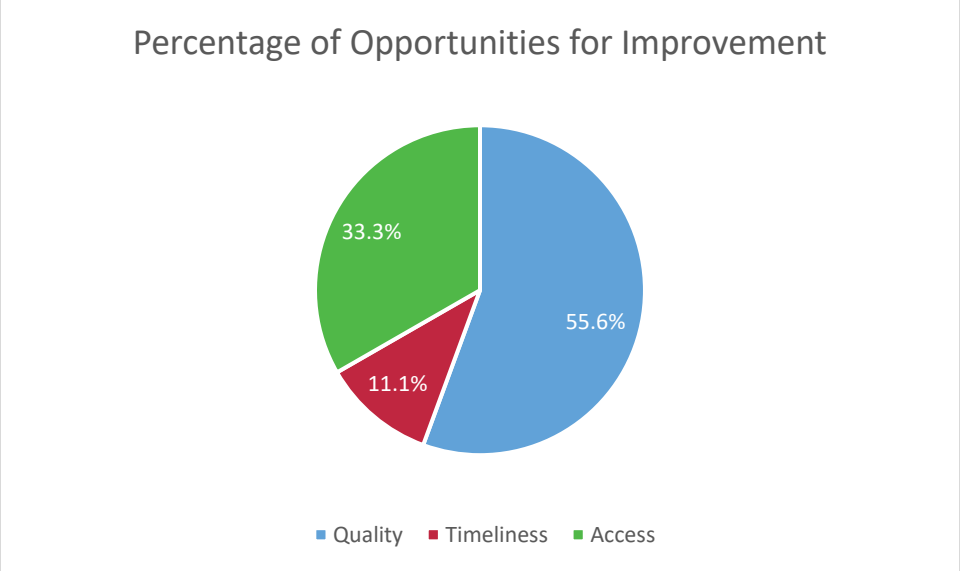
Rocky Mountain Health Plans

Figure 3-9—Percentage of Strengths by Care Domain for RMHP*



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

Figure 3-10—Percentage of Opportunities for Improvement by Care Domain for RMHP*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

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

Background: FY 2020–2021 PIP Activities

Table 3-33 and Table 3-34 summarize RMHP's PIP activities that were completed and validated in FY 2020–2021. Table 3-33 provides the SMART Aim statements that RMHP defined for the two PIP outcome measures in Module 1.

Table 3-33—SMART Aim Statements for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement*	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP members 12 years of age or older from 0.78% to 25.0%.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP members 12 years of age or older who screen positive for depression that are successfully connected to appropriate BH services within 30 days to the established benchmark of 46.89%.

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

Table 3-34 summarizes the preliminary key drivers and potential interventions RMHP identified to facilitate progress toward the SMART Aim goals in Module 2.

Table 3-34—Preliminary Key Drivers and Potential Interventions for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

FY 2021–2022 PIP Activities

In FY 2021–2022, RMHP continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, RMHP developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, RMHP submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as RMHP carried out PDSA cycles to evaluate intervention effectiveness. Table 3-35 presents the FY 2021–2022 Module 3 validation findings for RMHP's four interventions.

Table 3-35—FY 2021–2022 Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

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

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

In Module 3, RMHP selected four interventions to test for the PIP. The interventions addressed process gaps or failures related to clinic workflows, coding of depression screening results, and billing practices for depression screening and follow-up services. For each intervention, RMHP defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- Selecting four interventions to address key drivers and failure modes related to depression screening and follow-up care processes and facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of four interventions and developed a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. RMHP addressed all Module 3 PIP validation criteria.

To support successful progression of RMHP's PIP in the next fiscal year, HSAG recommends RMHP:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to RMHP's MY 2021 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 performance measure reporting. Please note HSAG could not confirm that the LO for RMHP conducted source code review for the non-HEDIS measures.

Performance Measure Results

Table 3-36 shows the performance measure results for RMHP for MY 2019 through MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-36—Performance Measure Results for RMHP

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Primary Care Access and Preventive Care				
Child and Adolescent Well-Care Visits[H]				
Total	—	45.15%	50.84%^	50th–74th
Childhood Immunization Status[H]				
Combination 3	20.50%	59.47%	52.00%	<10th
Combination 7	16.00%	53.74%	49.14%	10th–24th
Combination 10	11.00%	41.85%	42.86%	50th–74th
Chlamydia Screening in Women[H]				
Ages 16 to 20 Years	30.67%	30.77%	35.05%	<10th
Developmental Screening in the First Three Years of Life[CS]				
Total	—	—	57.54%	ACSM
Immunizations for Adolescents[H]				
Combination 1 (Meningococcal, Tdap)	62.86%	63.47%	68.90%	10th–24th
Combination 2 (Meningococcal, Tdap, HPV)	20.32%	28.44%	33.11%	25th–49th
Screening for Depression and Follow-Up Plan[SA]				
Ages 12 to 17 Years	—	—	6.81%	ASA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[H]				
BMI Percentile Documentation—Total	8.53%	13.63%	18.06%^	<10th
Counseling for Nutrition—Total	28.21%	25.20%	27.26%	<10th
Counseling for Physical Activity—Total	7.89%	6.52%	14.26%^	<10th

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Well-Child Visits in the First 30 Months of Life[H]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	22.69%	26.79%	<10th
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	75.24%	71.43%	50th–74th
Maternal and Perinatal Health				
Audiological Diagnosis No Later Than 3 Months of Age[SA]				
Total	—	—	NA	—
Contraceptive Care—All Women[CS]				
LARC—Ages 15 to 20 Years	—	—	5.49%	ACSM
MMEC—Ages 15 to 20 Years	—	—	24.39%	BCSM
Contraceptive Care—Postpartum Women[CS]				
LARC—3 Days—Ages 15 to 20 Years	—	—	NA	—
LARC—60 Days—Ages 15 to 20 Years	—	—	NA	—
MMEC—3 Days—Ages 15 to 20 Years	—	—	NA	—
MMEC—60 Days—Ages 15 to 20 Years	—	—	NA	—
Prenatal and Postpartum Care[H]				
Timeliness of Prenatal Care	—	—	NA	—
Care of Acute and Chronic Conditions				
Asthma Medication Ratio[CS]				
Total (Ages 5 to 18 Years)	—	—	82.50%	ACSM
Behavioral Health Care				
Follow-Up After Hospitalization for Mental Illness[H]				
7-Day Follow-Up—Ages 6 to 17 Years	—	—	35.48%	<10th
30-Day Follow-Up—Ages 6 to 17 Years	—	—	58.06%	<10th
Follow-Up Care for Children Prescribed ADHD Medication[H]				
Initiation Phase	55.88%	51.22%	40.91%	25th–49th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics[H]				
Blood Glucose Testing—Total	NA	NA	NA	—
Cholesterol Testing—Total	NA	NA	NA	—
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[H]				
Total	—	—	NA	—

Performance Measure	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	Benchmark Ranking
Use of Services				
Ambulatory Care: ED Visits				
*ED Visits—Total**	—	—	14.34	—

** For this indicator, a lower rate indicates better performance.*
[H] indicates that the measure is a HEDIS measure and can be compared to NCQA benchmarks.
[CS] indicates that the measure is a non-HEDIS Core Set measure and can be compared to the Core Set Median.
[SA] indicates that the measure could only be compared to the statewide average.
— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.
ASA indicates the reported rate was above the statewide average.
BCSM indicates the reported rate was below the Core Set Median.
ACSM indicates the reported rate was above the Core Set Median.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Red shading with two carets (^^) indicates a statistically significant decline in performance from MY 2020 to MY 2021.
Green shading with one caret (^) indicates a statistically significant improvement in performance from MY 2020 to MY 2021.

RMHP: Strengths

The following HEDIS MY 2021 measure rates were determined to be high-performing rates for RMHP (i.e., ranked at or above the 75th percentile without a significant decline in performance from MY 2020; or ranked between the 50th and 74th percentiles with a significant improvement in performance from MY 2020):

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

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates for RMHP (i.e., were above the Core Set Median):

- *Developmental Screening in the First Three Years of Life—Total*
- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years*
- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)*

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

The following HEDIS MY 2021 measure rates were determined to be low-performing rates for RMHP (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles with a significant decline in performance from MY 2019):

- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *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*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years and 30-Day Follow-Up—Ages 6 to 17 Years*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be low-performing rates for RMHP (i.e., were below the Core Set Median):

- *Contraceptive Care—All Women—MMEC—Ages 15 to 20 Years*

To address these low rates, HSAG recommends RMHP:

- Remind parents to protect their children against serous vaccine-preventable diseases. HSAG also recommends RMHP coordinate efforts between providers and public health officials at the local, state, and federal levels to achieve rapid catch-up vaccinations.[3-10]
- Promote well-care visits with providers as an opportunity for providers to influence health and development and reinforce that well-care visits are a critical opportunity for screening and counseling.[3-11]
- As it relates to source code review, perform a complete review of the calculation of the non-HEDIS measures and the HEDIS measures where the Core Set specifications differ from NCQA specifications (i.e., additional age stratifications) by the LO.

[3-10] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 24, 2022.

[3-11] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 24, 2022.

Assessment of Compliance With CHIP Managed Care Regulations

RMHP Overall Evaluation

Table 3-37 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2021–2022.

Table 3-37—Summary of RMHP Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	18	18	18	0	0	0	100%
Totals	**65**	**65**	**65**	**0**	**0**	**0**	**100%**

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

Table 3-38 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2021–2022.

Table 3-38—Summary of RMHP Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	76	76	0	14	100%
Totals	**190**	**162**	**162**	**0**	**28**	**100%**

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

RMHP: Trended Performance for Compliance With Regulations

Table 3-39 displays RMHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-39—Compliance With Regulations Trended Performance for RMHP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2016–2017, 2019–2020)	97%	91%
Standard II— Adequate Capacity and Availability of Services (2016–2017, 2019–2020)	100%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019, 2021–2022)	**80%**	**100%**
Standard IV—Member Rights, Protections, and Confidentiality (2015–2016, 2018–2019, 2021–2022)	**88%**	**100%**
Standard V—Member Information Requirements (2017–2018, 2020–2021)	100%	95%
Standard VI—Grievance and Appeal Systems (2017–2018, 2020–2021)	82%	97%
Standard VII—Provider Selection and Program Integrity (2017–2018, 2020–2021)	93%	94%
Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019, 2021–2022)	**100%**	**100%**
Standard IX—Subcontractual Relationships and Delegation (2017–2018, 2020–2021)	NA**	75%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2015–2016, 2018–2019, 2021–2022)	**83%**	**100%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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.*

In FY 2021–2022, RMHP scored 100 percent compliance across all four standards reviewed, maintaining 100 percent compliance in one standard: Standard VIII—Credentialing and Recredentialing. and reaching 100 percent compliance in the other three standards reviewed: Standard III—Coordination and Continuity of Care (from 80 to 100 percent); Standard IV—Member Rights, Protections, and Confidentiality (from 88 to 100 percent); and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (from 83 to 100 percent). Overall, seven of the 10 reviewed standards showed improvement from the previous review cycle or maintained 100 percent compliance, demonstrating compliance with federal healthcare regulations and a strong understanding of managed care contract requirements.

RMHP: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP conducted targeted outreach toward complex and high-risk health members, and its care coordination system platform provided secure access to member assessments, care plans, care management activities, and other information used for referrals, care coordination, and risk stratified members based on over 1,000 data markers that classify complex members from non-complex members. The new Impact Pro (IPro) model supported RMHP's ability to target high-risk members and, on a larger scale, included 300 newly identified complex CHP+ members.
- RMHP had a reported success rate of 25 to 30 percent in completing the initial screening during the welcome call.
- RMHP used concurrent and prior-authorization reviews to monitor for overutilization and underutilization to ensure members receive appropriate services.

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

HSAG found the following opportunities for improvement:

- Following outreach calls from care coordinators, RMHP did not send follow-up letters with detailed information and services discussed over the phone with the member.
- For the period under review, RMHP was unable to demonstrate within its reports an annual retrospective review of denied providers to verify that the denial was not based on discriminatory reasons.

To address these opportunities for improvement, HSAG recommends RMHP:

- Send follow-up letters to members as a best practice, notifying the member of the information and resources available to them.
- Conduct annual monitoring to ensure that providers are denied based on discriminatory reasons.

Validation of Network Adequacy

RMHP: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for RMHP:

- RMHP met all minimum time and distance network requirements for General and Pediatric BH, Pharmacies, and Adult Family and Pediatric Primary Care Practitioners (MD, DO, NP, CNS) across all contracted counties. 

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

HSAG found the following opportunities for improvement:

- RMHP did not meet the minimum time and distance network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for any of its contracted counties. Pediatric Specialties did not meet the minimum time and distance network requirements across multiple contracted counties. 

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

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

Findings

Table 3-40 shows the results achieved by RMHP for FY 2019–2020 through FY 2021–2022.

Table 3-40—Top-Box Scores for RMHP

Measure	FY 2019–2020 Score	FY 2020–2021 Score	FY 2021–2022 Score
Rating of Health Plan	69.3%	70.2%	70.7%
Rating of All Health Care	66.0%	74.3%	66.5%
Rating of Personal Doctor	72.0%	74.1%	73.4%
Rating of Specialist Seen Most Often	64.8%+	73.8%+	76.9%+
Getting Needed Care	85.2%	85.1%	88.7%
Getting Care Quickly	94.9%	89.6%	93.4%
How Well Doctors Communicate	97.2%	97.5%	95.5%
Customer Service	84.3%+	89.4%+	89.8%+

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

▲ *Indicates the FY 2021–2022 score is statistically significantly higher than the FY 2020–2021 score.*

▼ *Indicates the FY 2021–2022 score is statistically significantly lower than the FY 2020–2021 score.*

RMHP: Strengths

The following measures for RMHP showed an upward score trend over the three-year period:

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

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

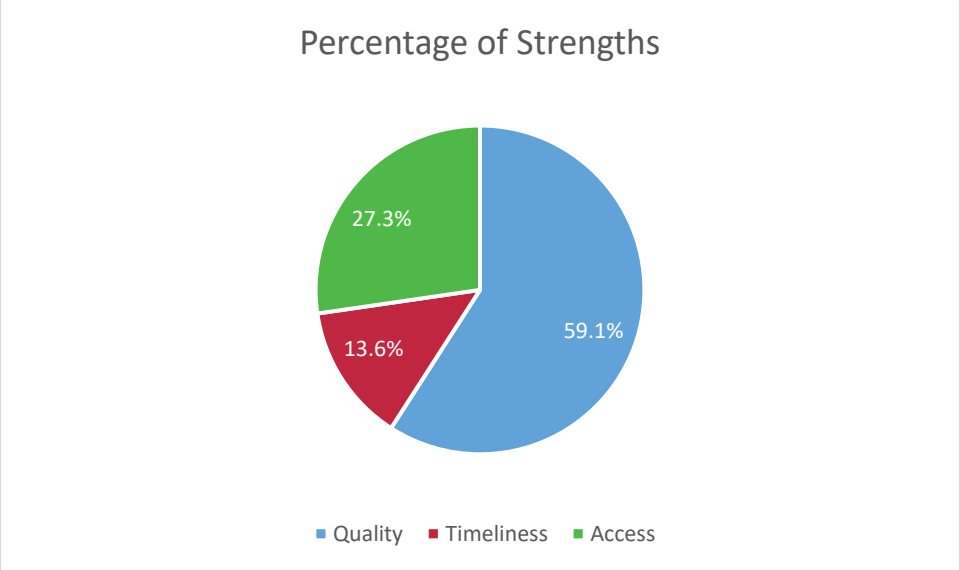
RMHP did not score statistically significantly lower in FY 2021–2022 than in FY 2020–2021, nor did RMHP show a downward score trend over the three-year period on any of the measures.

HSAG recommends RMHP:

- Consider if there are disparities within its populations that may contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

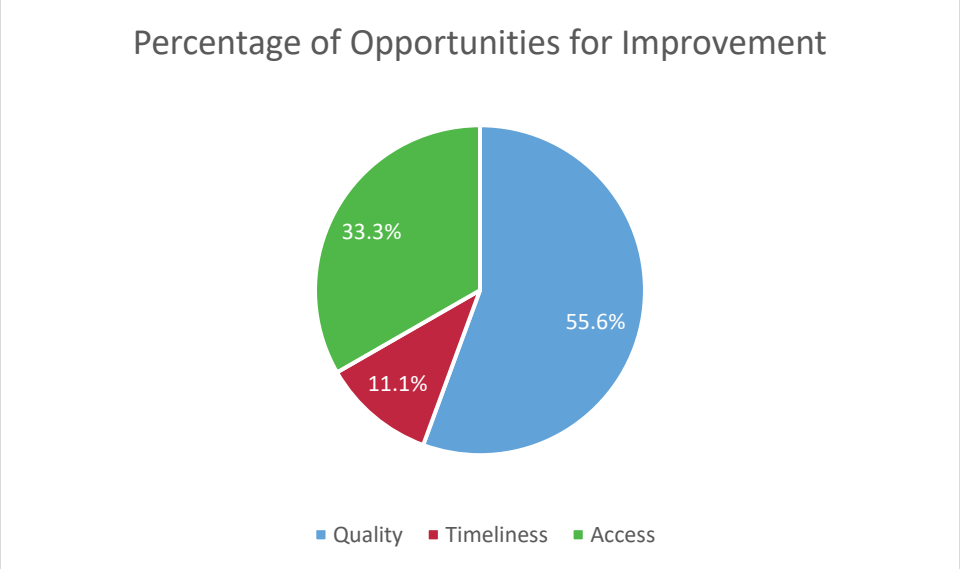
DentaQuest

Figure 3-11—Percentage of Strengths by Care Domain for DentaQuest*



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

Figure 3-12—Percentage of Opportunities for Improvement by Care Domain for DentaQuest*



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

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

Key:

- Quality =
- Timeliness =
- Access =

Validation of Performance Improvement Projects

Validation Activities and Interventions

In FY 2021–2022, DentaQuest continued the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP, which was initiated in FY 2020–2021. While the FY 2021–2022 PIP validation activities focused on Module 3—Intervention Testing, DentaQuest established a foundation for the project by completing the first two modules of HSAG's rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination, in FY 2020–2021. A summary of the previous year's PIP activities is included below to provide background and context for the FY 2021–2022 Module 3 PIP validation findings.

Background: FY 2020–2021 PIP Activities

Table 3-41 and Table 3-42 summarize DentaQuest's PIP activities that were completed and validated in FY 2020–2021. Table 3-41 provides the SMART Aim statement that DentaQuest defined for the PIP outcome measure in Module 1.

Table 3-41—SMART Aim Statement for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

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

Table 3-42 summarizes the preliminary key drivers and potential interventions DentaQuest identified to facilitate progress toward the SMART Aim goal in Module 2.

Table 3-42—Preliminary Key Drivers and Potential Interventions for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Preliminary Key Drivers	• Awareness of dental benefits. • Access to dental services. • Provider participation to encourage benefit utilization. • Caregiver understanding of the importance of oral health in primary teeth.
Potential Interventions	• Provide outreach and education to member/caregiver on dental benefits and the importance of early oral health. • Collaborate with community partners to distribute dental benefit information. • Partner with network dental providers to offer non-traditional modes of dental care. • Document and distribute information on flexible dental provider office hours. • Notify member's assigned dental provider if no dental service has been received in the past 12 months. • Implement a dental home care model for Colorado CHP+ members. • Partner with schools to engage children and parents in oral health and prevention.

FY 2021–2022 PIP Activities

In FY 2021–2022, DentaQuest continued the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP and submitted Module 3—Intervention Testing for validation. Module 3 initiates the intervention testing phase of the PIP process. During this phase, DentaQuest developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, DentaQuest submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as DentaQuest carried out PDSA cycles to evaluate intervention effectiveness. Table 3-43 presents the FY 2021–2022 Module 3 validation findings for DentaQuest's two interventions.

Table 3-43—FY 2021–2022 Module 3 Validation Findings for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Free online provider training on preventing early childhood dental caries, with continuing education credits, offered to	• Parent/Guardian of member does not receive reinforcing education on importance of care on primary teeth	• Parent/Guardian understanding of the importance of oral health in primary teeth	• Percentage of general and pediatric dentists in Weld County who were notified of the availability of the "ECC [Early Childhood

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
general and pediatric dentists in Weld County			Caries] Management for the General Dentist" online training and who completed the training
Outreach with incentive offered to members and their caregivers to seek dental services by offering appointment scheduling assistance and a backpack with age-appropriate oral health materials for completing the visit	• Parent/Guardian of member does not open/does not receive educational packet on dental benefits and importance of preventive care on primary (baby) teeth	• Parent/Guardian understanding of the importance of oral health in primary teeth	• Percentage of eligible members who were successfully reached for a direct call offering the incentive for completing a dental visit • Percentage of members ages 3–5 years who reside in Weld County and have not received a dental visit in the previous 18 months who completed a dental visit during the intervention period

In Module 3, DentaQuest selected two interventions to test for the PIP. The interventions addressed process gaps in supporting caregiver awareness of the importance of oral health in primary teeth among children 3–5 years of age. For each intervention, DentaQuest defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions.

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 continued 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

Based on PIP validation activities conducted in FY 2021–2022, HSAG found the following strengths for DentaQuest:

- Selecting two interventions to address key drivers and failure modes related to dental utilization processes and facilitate achievement of the SMART Aim goals for improvement.
- Initiated testing of two interventions and developed a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles.

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

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. DentaQuest addressed all Module 3 PIP validation criteria.

To support successful progression of DentaQuest's PIP in the next fiscal year, HSAG recommends DentaQuest:

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

Validation of Performance Measures

Compliance With Information Systems Standards

According to DentaQuest's MY 2021 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 performance measure reporting.

Performance Measure Results

Table 3-44 shows the performance measure results for DentaQuest for MY 2021, along with the percentile rankings for each MY 2021 rate.

Table 3-44—Performance Measure Results for DentaQuest

Performance Measure	Eligible Population	MY 2021 Rate	Percentile Ranking
Dental			
Sealant Receipt on Permanent First Molars			
At Least One Sealant	2,797	24.49%	ACSM
All Four Molars Sealed	2,797	14.30%	ACSM
Percentage of Eligibles Who Received Preventive Dental Services			
Total	64,176	42.11%	ACSM

ACSM indicates the reported rate was above the Core Set Median.

DentaQuest: Strengths

The following MY 2021 measure rates were determined to be high-performing rates for DentaQuest (i.e., were above the Core Set Median):

- *Sealant Receipt on Permanent First Molars—At Least One Sealant* and *All Four Molars Sealed* 
- *Percentage of Eligibles Who Received Preventive Dental Services—Total*

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

HSAG did not identify any opportunities for improvement for DentaQuest when conducting the PMV activity.

Assessment of Compliance With CHIP Managed Care Regulations

DentaQuest Overall Evaluation

Table 3-45 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 2021–2022.

Table 3-45—Summary of DentaQuest Scores for the FY 2021–2022 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	4	6	0	0	40%
Standard IV—Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	5	5	0	0	27	100%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems	16	16	8	8	0	0	50%
Totals	**63**	**36**	**22**	**14**	**0**	**27**	**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 3-46 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 2021–2022.

Table 3-46—Summary of DentaQuest Scores for the FY 2021–2022 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Credentialing	100	89	89	0	11	100%
Recredentialing	126	72	69	3	9	96%
Totals	**226**	**161**	**158**	**3**	**20**	**98%**

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

DentaQuest: Trended Performance for Compliance With Regulations

As FY 2019–2020 was the initial year of DentaQuest's CHP+ contract, Standard VI—Grievance and Appeal Systems was the only standard with trended performance between compliance review cycles. DentaQuest improved the Standard VI—Grievance and Appeal Systems score by 61 percentage points between the two most recent cycles (FY 2019–2020 and FY 2020–2021), increasing its compliance score from 13 percent to 74 percent. In FY 2021–2022, DentaQuest received the lowest overall compliance score (61 percent) and the lowest scores for Standard III—Coordination and Continuity of Care (40 percent) and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (50 percent) in comparison to the CHP+ MCOs.

DentaQuest: Strengths

Based on the four standards reviewed in FY 2021–2022, HSAG found the following strengths for DentaQuest:

- DentaQuest considered several factors when deciding where to place a member such as member's history at a dental home, the distance between the member's home and the dental home, the member's age, and the capacity of the dental home location.
- After enrollment, DentaQuest described an outreach approach to provide members with their dental home contact information and allowed members direct access to a specialist, as appropriate for the member's condition and identified needs.

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

HSAG found the following opportunities for improvement:

- DentaQuest did not have policies and procedures regarding expectations for initial assessments, coordination of care, or members with SHCN.
- DentaQuest did not have a link to the Spanish member handbook on the organization's website.
- DentaQuest did not demonstrate within its policies or procedures an annual retrospective review of denied providers to verify that the denial was not based on discriminatory reasons.
- DentaQuest described data sorting issues, which resulted in the plan submitting five initial credentialing files for record review within the recredentialing sample. Drug Enforcement Agency (DEA) certificates were lacking in three recredentialing record review samples.
- DentaQuest did not provide evidence to show it reviewed CHP+-specific elements such as PIPs, performance measures, member satisfaction data, over- and underutilization, assessment of the quality and appropriateness of care for members with SHCN, or CPGs at its National Quality Improvement Committee. Additionally, DentaQuest did not provide evidence of an annual CHP+ QAPI evaluation.

- DentaQuest did not outline a process for submitting encounter claims data to the Department and verifying the accuracy and timeliness of data.

To address these opportunities for improvement, HSAG recommends DentaQuest:

- develop and implement procedures that meet State requirements for coordinating and delivering care; defining SHCN, and clarifying expectations regarding providers developing treatment plans for members with SHCN.
- Update its website to include the Spanish member handbook.
- Develop an annual review mechanism that monitors to ensure providers are not denied based on discriminatory reasons.
- Review internal procedures for extracting and handling credentialing data to ensure accurate internal and external reporting.
- Enhance its documentation and internal auditing process to ensure that primary source verification for DEA certification occurs.
- Develop and implement an ongoing comprehensive QAPI program for services it furnishes to its CHP+ members that incorporates PIP activities, performance measure reporting, monitoring of over- and underutilization, assessment of member satisfaction, quality and appropriateness of care furnished to members with SHCN, and other key QAPI elements that are specific to the CHP+ line of business (LOB). Additionally, develop a process for evaluating the impact and effectiveness of the QAPI program at least annually that is specific to the CHP+ LOB.
- Develop a policy, procedure, or desk protocol to verify the accuracy and timeliness of claims data, and a process for submitting encounter claims data to the Department.
- Develop a communication and monitoring plan to ensure that member, provider, and utilization management staff messaging, and use of CPGs are consistent.

Validation of Network Adequacy

DentaQuest: Strengths

Based on NAV activities conducted in FY 2021–2022, HSAG found the following strengths for DentaQuest:

- While DentaQuest did not meet all minimum time and distance network requirements across all counties in each county designation, its General Dentist network performs fairly well with six counties not meeting the standard; however, of those six counties not meeting the standard, five counties are less than 1 percentage point away from meeting the standard. 

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

HSAG found the following opportunities for improvement:

- DentaQuest did not meet the minimum time and distance network requirements for more than half of its contracted counties for Oral Surgeons and Pediatric Dentists. 

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

- Seek opportunities to expand the care network to ensure adequate network providers and member access to care according to the minimum time and distance standards.

CAHPS Survey

A CAHPS survey was not conducted for Colorado's dental PAHP, DentaQuest.

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

Validation of Performance Improvement Projects

Table 4-1 shows the FY 2021–2022 statewide PIP results for the CHP+ health plans.

Table 4-1—FY 2021–2022 PIP Results for the CHP+ Health Plans

Health Plan	PIP Topic	Module Status	Validation Status
COA	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
DHMP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
FHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
Kaiser	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	NA
RMHP	*Depression Screening and Follow-Up After a Positive Depression Screen*	*Completed Module 1, Module 2, and Module 3*	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, Module 2, and Module 3*	NA

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2021–2022 validation cycle.*

Statewide Conclusions and Recommendations for PIPs

During FY 2021–2022, the MCEs continued ongoing PIPs focused on *Depression Screening and Follow-Up After a Positive Depression Screen.* The PIPs were initiated in the prior fiscal year when the MCEs had completed the first two modules of the rapid-cycle PIP process, Module 1—PIP Initiation and Module 2—Intervention Determination. During this validation cycle, the MCEs submitted Module 3 of the rapid-cycle PIP process for validation. In Module 3—Intervention Testing, the MCE defines the plan for the intervention to be tested. HSAG provided technical assistance and feedback to the MCEs on the intervention testing plan, including the intervention effectiveness measure and data collection process. The MCEs continued testing interventions for the PIP until the end of the fiscal year. In FY 2022–2023, the MCEs will submit the final rapid-cycle PIP module, Module 4—PIP Conclusions for validation and will report the final results, conclusions, and lessons learned for the PIPs.

HSAG did not identify any opportunities for improvement when conducting the Module 3 validation in FY 2021–2022. All MCEs addressed all Module 3 PIP validation criteria.

To support successful progression of the PIPs in the next fiscal year, HSAG recommends:

- The MCEs collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should report and interpret intervention testing results for each intervention, which will be submitted for validation as part of Module 4—PIP Conclusions.
- The MCEs ensure that the approved SMART Aim data collection methodology is used consistently to calculate SMART Aim measure results throughout the project. Using a consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, the MCEs develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, the MCEs synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to reporting any improvement achieved through the project, the MCEs should document which interventions had the greatest impact.
- Since all MCEs except DentaQuest are focusing on the same PIP topic, *Depression Screening and Follow-Up After a Positive Depression Screen*, the Department consider providing an opportunity for the MCEs to share successful improvement strategies and lessons learned with one another once the PIPs are completed. Such an approach may support the spread of successful interventions across the broader Medicaid population, furthering statewide improvement in depression screening and follow-up care outcomes.

Validation of Performance Measures

Table 4-2 presents the MCO-specific and statewide weighted averages for the CHP+ MCOs for HEDIS MY 2021. 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 2021

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Primary Care Access and Preventive Care						
Child and Adolescent Well-Care Visits						
Total	48.16%	47.87%	0.00%	44.27%	50.84%	46.98%
Childhood Immunization Status						
Combination 3	65.97%	52.00%	NA	77.06%	52.00%	64.91%
Combination 7	57.35%	48.00%	NA	69.72%	49.14%	57.91%
Combination 10	46.81%	44.00%	NA	56.88%	42.86%	48.48%
Chlamydia Screening in Women						
Ages 16 to 20 Years	34.66%	38.33%	NA	47.12%	35.05%	36.58%
Developmental Screening in the First Three Years of Life						
Total	—	—	—	—	57.54%	57.54%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	76.45%	64.97%	0.00%	80.12%	68.90%	73.38%
Combination 2 (Meningococcal, Tdap, HPV)	37.74%	42.94%	0.00%	42.47%	33.11%	37.06%
Screening for Depression and Follow-Up Plan						
Ages 12 to 17 Years	—	—	—	—	6.81%	6.81%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	16.32%	72.47%	NA	90.75%	18.06%	26.61%
Counseling for Nutrition—Total	13.92%	77.72%	NA	92.77%	27.26%	26.82%
Counseling for Physical Activity—Total	9.37%	77.33%	NA	93.12%	14.26%	21.63%
Well-Child Visits in the First 30 Months of Life						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.19%	50.00%	NA	16.67%	26.79%	47.60%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	65.48%	63.29%	19.35%	47.55%	71.43%	63.58%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Maternal and Perinatal Health						
Audiological Diagnosis No Later Than 3 Months of Age						
Total	—	—	—	—	NA	NA
Contraceptive Care—All Women						
LARC—Ages 15 to 20 Years	—	—	—	—	5.49%	5.49%
MMEC—Ages 15 to 20 Years	—	—	—	—	24.39%	24.39%
Contraceptive Care—Postpartum Women						
LARC—3 Days—Ages 15 to 20 Years	—	—	—	—	NA	NA
LARC—60 Days—Ages 15 to 20 Years	—	—	—	—	NA	NA
MMEC—3 Days—Ages 15 to 20 Years	—	—	—	—	NA	NA
MMEC—60 Days—Ages 15 to 20 Years	—	—	—	—	NA	NA
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	56.92%	NA	NA	NA	NA	54.95%
Care of Acute and Chronic Conditions						
Asthma Medication Ratio						
Total (Ages 5 to 18 Years)	75.43%	NA	NA	91.18%	82.50%	76.42%
Behavioral Health Care						
Follow-Up After Hospitalization for Mental Illness						
7-Day Follow-Up—Ages 6 to 17 Years	36.42%	NA	NA	NA	35.48%	41.15%
30-Day Follow-Up—Ages 6 to 17 Years	54.91%	NA	NA	NA	58.06%	58.85%
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	29.03%	NA	—	37.14%	40.91%	32.05%
Continuation and Maintenance Phase	38.60%	NA	—	NA	NA	40.79%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
Blood Glucose Testing—Total	50.00%	NA	NA	NA	NA	53.02%
Cholesterol Testing—Total	27.19%	NA	NA	NA	NA	28.86%
Blood Glucose and Cholesterol Testing—Total	27.19%	NA	NA	NA	NA	28.86%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics						
Total	72.00%	NA	NA	NA	NA	71.01%

Performance Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Use of Services						
Ambulatory Care: ED Visits						
*ED Visits—Total**	19.23	13.31	NA	—	14.34	18.02

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

— indicates that a percentile ranking was not determined because the rate was not reportable or there was a break in trending. This symbol may also indicate that the denominator was too small to report the rate, there was no benchmark to compare to, or that the plan was exempted from the rate.

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

Statewide Strengths

The following statewide HEDIS MY 2021 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 2020; or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS MY 2020) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combination 10*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*

The following non-HEDIS MY 2021 Core Set measure rates were determined to be high-performing rates (i.e., ranked at or above the Core Set Median):

- *Developmental Screening in the First Three Years of Life—Total*
- *Contraceptive Care—All Women—LARC—Ages 15 to 20 Years*
- *Asthma Medication Ratio—Total (Ages 5 to 18 Years)*

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

The following statewide HEDIS MY 2021 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 2020) for the CHP+ statewide weighted average:

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

- *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*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years* and *30-Day Follow-Up—Ages 6 to 17 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

The following non-HEDIS MY 2021 Core Set measure rate was determined to be a low-performing rate (i.e., ranked below the Core Set Median):

- *Contraceptive Care—All Women—MMEC—Ages 15 to 20 Years*

To address these low measure rates, HSAG recommends:

- Reminding parents to protect their children against serious vaccine-preventable diseases. HSAG also recommends coordinating efforts between providers and public health officials at the local, State, and federal levels to achieve rapid catch-up vaccinations.[4-1]
- Promoting well-care visits with providers as an opportunity for providers to influence health and development and reinforcing that well-care visits are a critical opportunity for screening and counseling.[4-2]

[4-1] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Oct 26, 2022.

[4-2] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Oct 26, 2022.

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—Adequate Capacity and Availability of Services (2019–2020)	100%	88%	81%	100%	100%	69%	90%
Standard III—Coordination and Continuity of Care (2018–2019, 2021–2022)	**100%**	**100%**	**50%**	**100%**	**100%**	**40%**	**82%**
Standard IV—Member Rights, Protections, and Confidentiality (2018–2019, 2021–2022)	**100%**	**100%**	**80%**	**60%**	**100%**	**100%**	**90%**
Standard V—Member Information Requirements (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 Selection (Selection) and Program Integrity (2020–2021)	100%	93%	75%	100%	94%	87%	91%
Standard VIII—Credentialing and Recredentialing (2018–2019, 2021–2022)	**100%**	**97%**	**77%**	**100%**	**100%**	**100%**	**96%**
Standard IX—Subcontractual Relationships and Delegation (2020–2021)	100%	75%	50%	75%	75%	100%	79%
Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems (2018–2019, 2021–2022)	**94%**	**100%**	**67%**	**100%**	**100%**	**50%**	**85%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

**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, 2021–2022)	**100%**	**100%**	**99%**	**100%**	**100%**	**100%**	**100%**
Denials (2019–2020)	66%	83%	75%	66%	97%	65%	75%
Grievances (2020–2021)	96%	78%	NA	98%	97%	94%	93%
Recredentialing (2018–2019, 2021–2022)	**100%**	**100%**	**96%**	**100%**	**100%**	**96%**	**99%**

Bold text indicates standards reviewed by HSAG during FY 2021–2022.

Statewide Conclusions and Strengths Related to Compliance With Regulations

Per the results of the three-year compliance review cycle (FY 2019–2020, FY 2020–2021, and FY 2021–2022), 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.

During the FY 2021–2022 review period, HSAG found the following common strengths among the CHP+ health plans:

- CHP+ health plans demonstrated high levels of compliance with the Department's credentialing and recredentialing requirements, which averaged 96 percent compliance, and record review scores reached 99 and 100 percent compliance respectively across the CHP+ health plans during FY 2021–2022.
- Most CHP+ health plans informed members of their rights through the member handbook, member newsletters, the health plan website, notice of privacy practices, and other posted or mailed materials. Most CHP+ health plans operated member advisory councils to monitor and respond to any issues with member rights, although few issues were reported.
- Most CHP+ health plans had policies and procedures to assess and coordinate services for members, including those with complex needs, identified health risks, or SHCN.
- Most CHP+ health plans demonstrated organized QAPI structures that included detailed reviews of key data elements, reports, and feedback from leadership regarding improvement opportunities.

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 across the state during the FY 2019–2020 reviews.

During the FY 2021–2022 review period, the lowest scoring standards both only reached an average of 82 percent and 85 percent compliance (Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement, Clinical Practice Guidelines, and Health Information Systems). HSAG found the following most common opportunities for improvement among the CHP+ health plans:

- After the outreach call detailing the care coordination information provided over the phone, many CHP+ health plans did not send a follow-up letter restating the information provided during the outreach call. HSAG recommends the CHP+ health plan consider sending a follow-up letter to the member detailing the information provided during the outreach call should the member want to reach out to their care coordinator.
- Two CHP+ health plans did not adequately outline how they assessed and identified member needs, and followed up in a timely manner. These CHP+ health plans must develop or revise policies and procedures to ensure information is clearly outlined and monitored.
- One CHP+ health plan did not have a current policy or procedure as required for Standard IV—Member Rights, Protections, and Confidentiality and was required to reinstate and update a member rights policy.
- Multiple CHP+ health plans could not demonstrate an annual retrospective review to verify that decisions to deny providers from joining the network were not based on discriminatory reasons.
- Within some record review files for credentialing and recredentialing, HSAG found a significant gap between initial review and medical director or committee approval. The CHP+ health plans were required to enhance procedures to ensure final approval is within the appropriate time limits.
- Processes to monitor and identify provider grievances and quality issues were not in place for some CHP+ health plans' credentialing departments, including how the information is used to review, trend, and train, as needed. Those CHP+ health plans were required to implement processes and a mechanism to identify grievances and quality issues.
- One CHP+ health plan did not have a comprehensive QAPI program to assess, monitor, and evaluate the quality and appropriateness of member care against goals. The health plan was required to develop and enhance QAPI procedures specifically regarding its CHP+ members.

Validation of Network Adequacy

Statewide Results

Quarterly during FY 2021–2022, HSAG validated the MCEs' self-reported compliance with minimum network requirements and provided the Department with both MCE-specific initial file review results in the network adequacy data initial validation (NADIV) dashboards and final validation results in quarterly NAV dashboards.

The data-related findings in this report align with HSAG's validation of the MCEs' FY 2021–2022 Quarter 2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2021, through December 31, 2021.

For an MCE to be compliant with the FY 2021–2022 minimum network requirements, the MCE is required to ensure that its practitioner network is such that 100 percent of its members have addresses within the minimum network requirement (i.e., 100 percent access level). For example, all members residing in an urban county (e.g., Denver County) must live within 30 miles or 30 minutes of at least two family practitioners. However, if members reside in counties outside their MCE's contracted geographic area, the Department does not necessarily require the MCE to meet the minimum network requirements for those members. Additionally, the MCE 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).

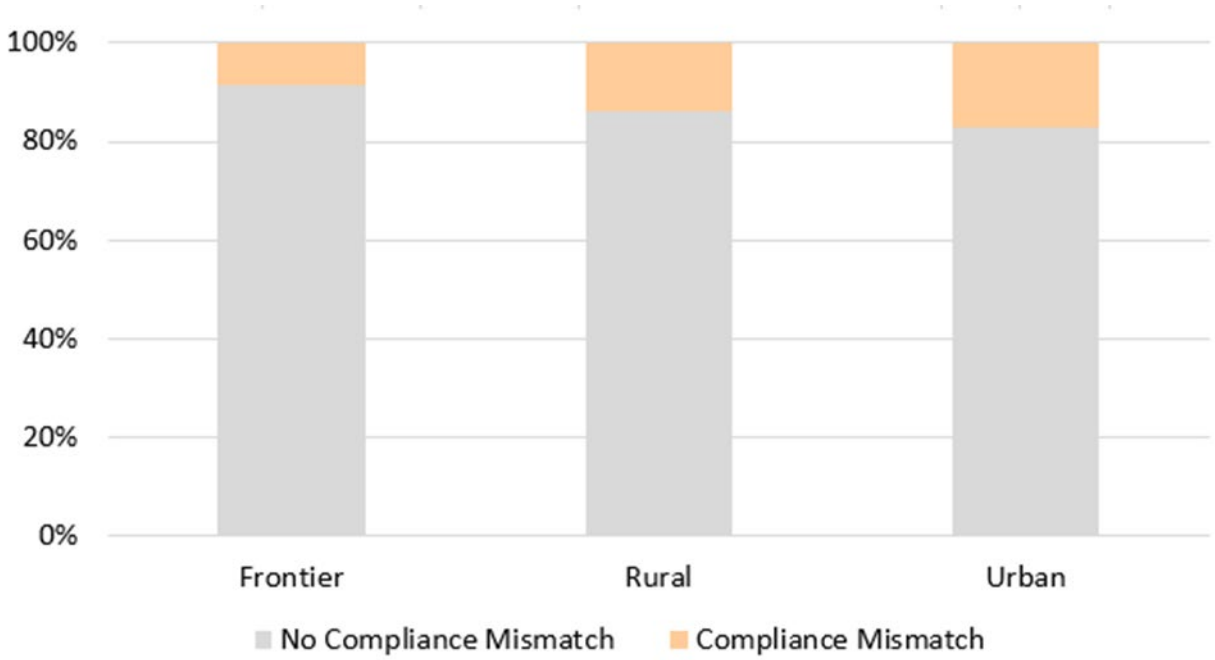
CHP+ Managed Care Organizations

This section summarizes the FY 2021–2022 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 2021–2022 by Urbanicity

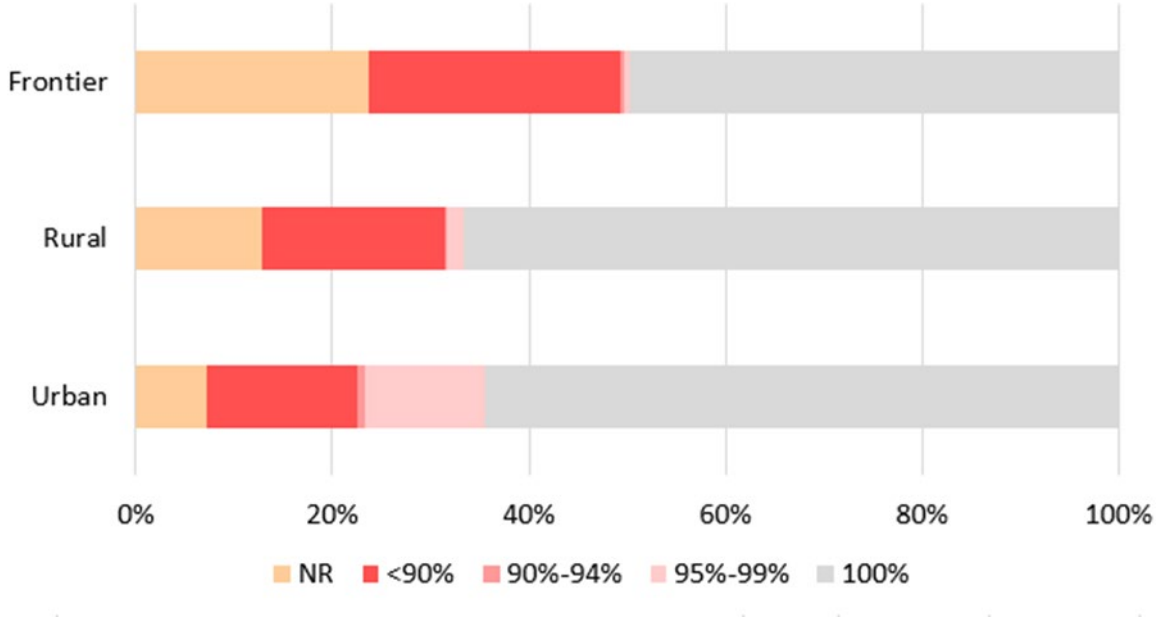


As shown in Figure 4-1, HSAG agreed with 91.3 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 86.2 percent of reported results for rural counties, and 83.0 percent of reported results for urban counties. HSAG disagreed with 8.7 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 13.8 percent of reported results for rural counties, and 17.0 percent of reported results for urban counties.

Access Level Assessment

Figure 4-2 displays the percentage of aggregate CHP+ MCO physical health primary care results within the time and distance network requirements for varying levels of access, by urbanicity as of December 31, 2021.

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, 2021

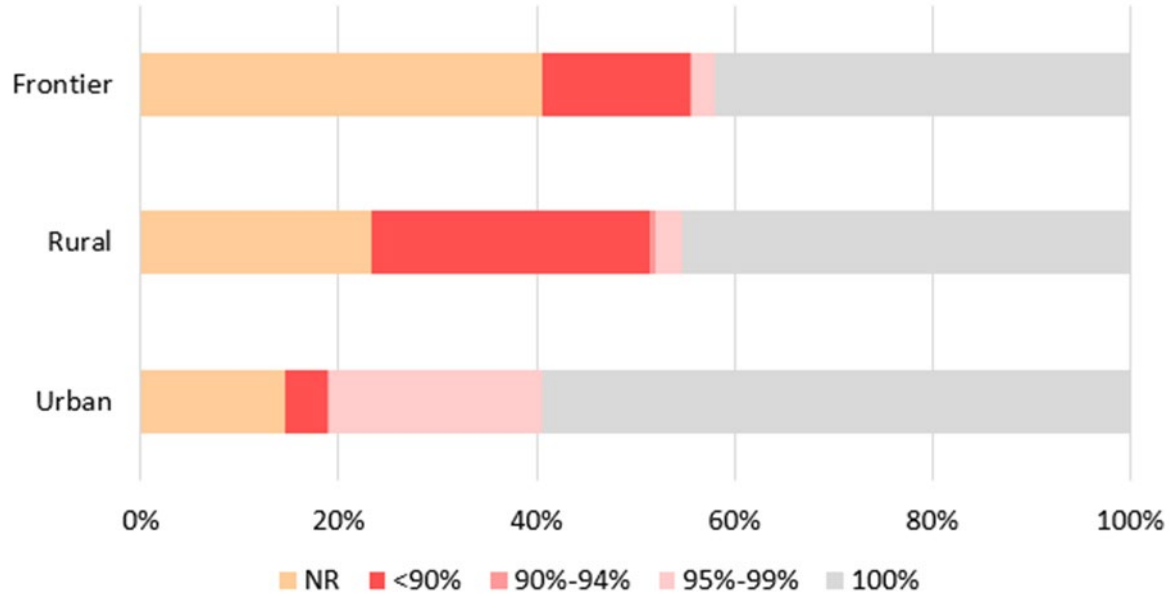


- The top bar in Figure 4-2 reflects a total of 296 physical health primary care results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 296 CHP+ MCO frontier results, 49.7 percent (n=147) 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 1.0 percent (n=3) 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 25.7 percent (n=76) 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, 23.7 percent (n=70) of the results have no CHP+ MCO members within the appropriate age range for the physical health primary care requirements residing in the contracted frontier counties.
- The middle bar in Figure 4-2 reflects a total of 344 physical health primary care results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 344 CHP+ MCO rural results, 66.7 percent (n=229) have 100 percent access level, 2.0 percent (n=7) of the results have 90 to 99 percent access level, and 18.6 percent (n=64) of the results have less than 90 percent access level. As expected, 12.8 percent (n=44) of the results have no CHP+ MCO members within the appropriate age range for the physical health primary care requirements residing in the contracted rural counties.

- The bottom bar in Figure 4-2 reflects a total of 248 physical health primary care results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 248 CHP+ MCO urban results, 64.5 percent (n=160) have 100 percent access level, 12.1 percent (n=32) of the results have 90 to 99 percent access level, and 15.3 percent (n=38) of the results have less than 90 percent access level. As expected, 7.3 percent (n=18) of the results have no CHP+ MCO members within the appropriate age range for the physical health primary care requirements residing in the contracted urban counties.

Figure 4-3 displays the percentage of 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 2021–2022 Quarter 2. 'NR' indicates that no CHP+ MCO members had access within the criteria for the primary care network requirements for the selected counties.[4-3]

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, 2021



- The top bar in Figure 4-3 reflects a total of 740 physical health specialist results (i.e., minimum network requirement and county combinations), summarizing the percentage of members who had access within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 740 CHP+ MCO frontier results, 42.0 percent (n=311) have 100 percent of CHP+ MCO members with residential addresses in frontier counties that had access

[4-3] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

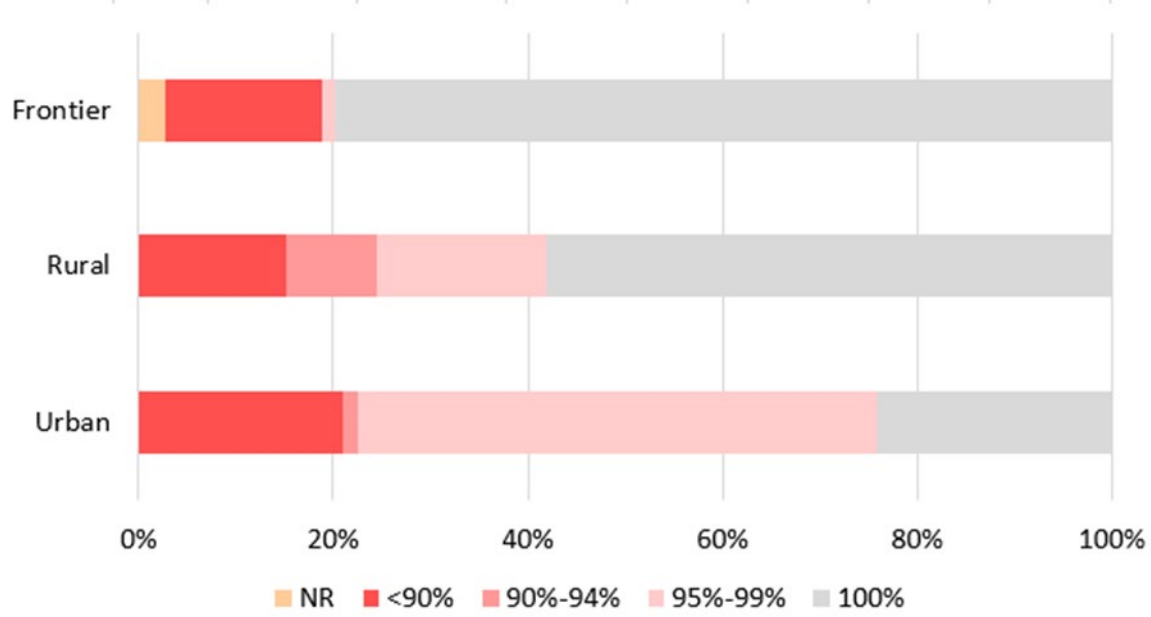
within the minimum network requirements (i.e., 100 percent access level). An additional 2.4 percent (n=18) of the results have 90 to 99 percent of members that reside within frontier counties that had access within the minimum network requirements (i.e., 90 to 99 percent access level), and 15.0 percent (n=111) 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, 40.5 percent (n=300) 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 860 physical health specialist results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 860 CHP+ MCO rural results, 45.2 percent (n=389) have 100 percent access level, 3.4 percent (n=29) of the results have 90 to 99 percent access level, and 28.1 percent (n=242) of the results have less than 90 percent access level. As expected, 23.3 percent (n=200) of the results have no CHP+ MCO members within the appropriate age range for the physical health specialist requirements residing in the contracted rural counties.
- The bottom bar in Figure 4-3 reflects a total of 620 physical health specialist results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 620 CHP+ MCO urban results, 59.4 percent (n=368) have 100 percent access level, 21.8 percent (n=135) of the results have 90 to 99 percent access level, and 4.4 percent (n=27) of the results have less than 90 percent access level. As expected, 14.5 percent (n=90) 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 percentage 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 2021–2022 Quarter 2. 'NR' indicates that no CHP+ MCO members had access within the criteria for the primary care network requirements for the selected counties.[4-4]

[4-4] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

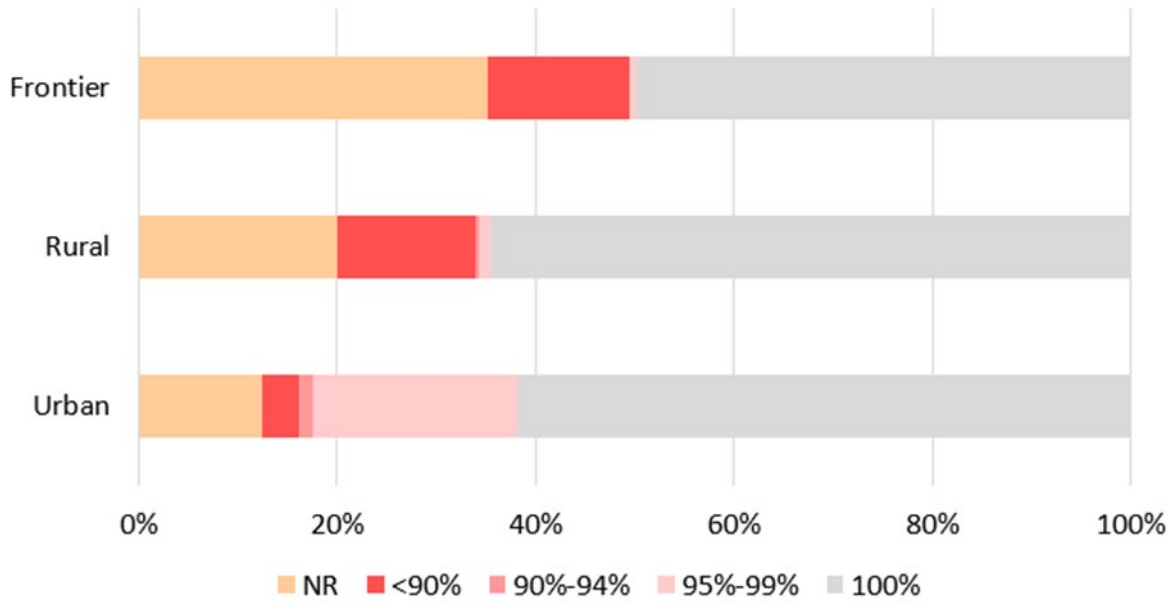
Figure 4-4—Percentage of Aggregate CHP+ MCO Physical Health Entity Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021



- The top bar in Figure 4-4 reflects a total of 74 physical health entity results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 74 CHP+ MCO frontier results, 79.7 percent (n=59) 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 1.4 percent (n=1) 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 16.2 percent (n=12) 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). Finally, 2.7 percent (n=2) of the results have no CHP+ MCO members residing in the contracted frontier counties.
- The middle bar in Figure 4-4 reflects a total of 86 physical health entity results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 86 CHP+ MCO rural results, 58.1 percent (n=50) have 100 percent access level, 26.7 percent (n=23) of the results have 90 to 99 percent access level, and 15.1 percent (n=13) of the results have less than 90 percent access level.
- The bottom bar in Figure 4-4 reflects a total of 62 physical health entity results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 62 CHP+ MCO urban results, 24.2 percent (n=15) have 100 percent access level, 54.8 percent (n=34) of the results have 90 to 99 percent access level, and 21.0 percent (n=13) of the results have less than 90 percent access level.

Figure 4-5 displays the percentage of BH results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2021–2022 Quarter 2. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the BH requirements for the selected counties.[4-5]

Figure 4-5—Percentage of Aggregate CHP+ MCO BH Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2021



- The top bar in Figure 4-5 reflects a total of 259 BH results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the combined CHP+ MCOs are contracted to serve. Of those 259 CHP+ MCO frontier results, 49.8 percent (n=129) 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 0.8 percent (n=2) 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 14.3 percent (n=37) 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, 35.1 percent (n=91) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted frontier counties.
- The middle bar in Figure 4-5 reflects a total of 301 BH results, summarizing the percentage of members within each minimum network requirement and rural Colorado county the combined CHP+ MCOs are contracted to serve. Of those 301 CHP+ MCO rural results, 64.5 percent (n=194) have

[4-5] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results.

100 percent access level, 1.7 percent (n=5) of the results have 90 to 99 percent access level, and 14.0 percent (n=42) of the results have less than 90 percent access level. As expected, 19.9 percent (n=60) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted rural counties.

- The bottom bar in Figure 4-5 reflects a total of 217 BH results, summarizing the percentage of members within each minimum network requirement and urban Colorado county the combined CHP+ MCOs are contracted to serve. Of those 217 CHP+ MCO urban results, 61.8 percent (n=134) have 100 percent access level, 22.1 percent (n=48) of the results have 90 to 99 percent access level, and 3.7 percent (n=8) of the results have less than 90 percent access level. As expected, 12.4 percent (n=27) of the results have no CHP+ MCO members within the appropriate age range for the BH requirements residing in the contracted urban counties.

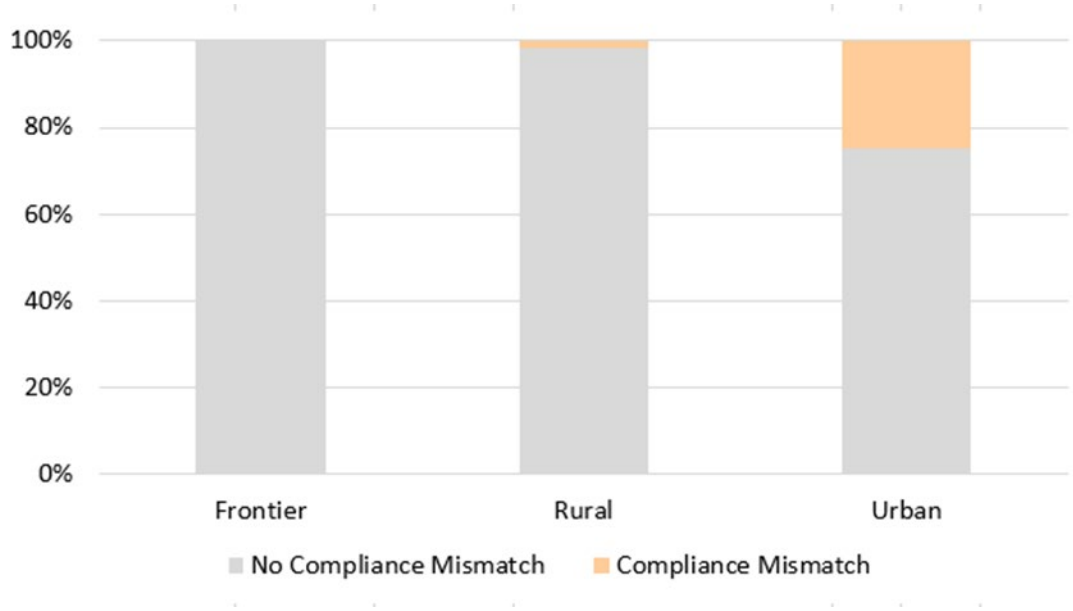
Dental Prepaid Ambulatory Health Plan

This section summarizes the FY 2021–2022 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 2021–2022 Quarter 2 by Urbanicity

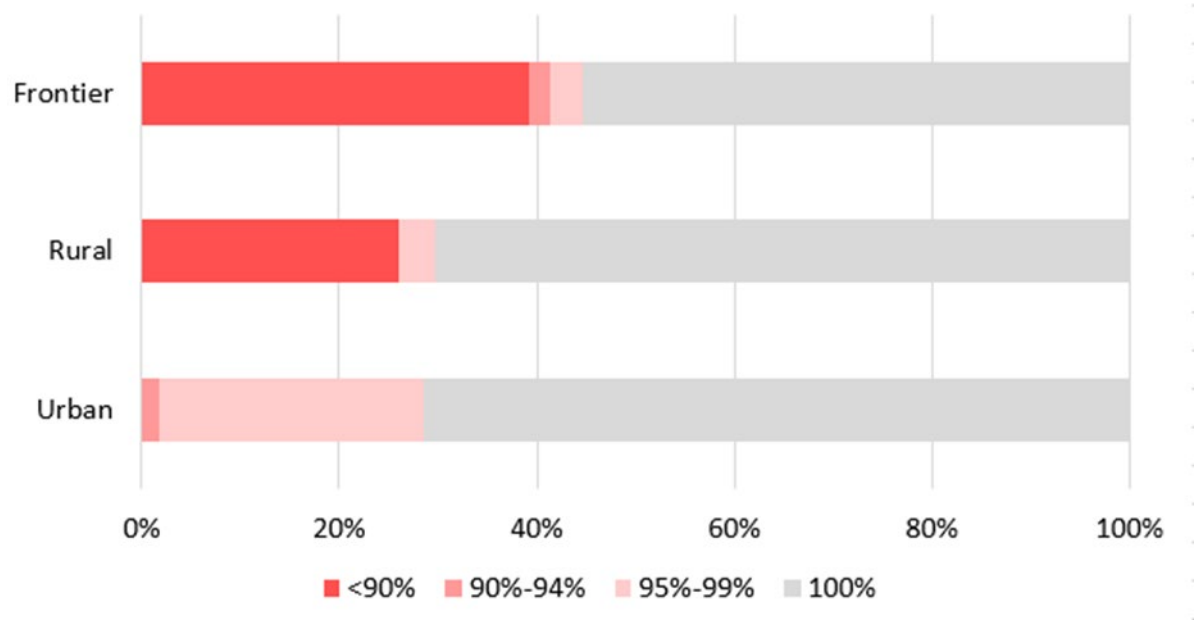


As shown in Figure 4-6, HSAG agreed with 100 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 98.2 percent of reported results for rural counties, and 75.0 percent of reported results for urban counties. HSAG disagreed with 1.8 percent of the PAHP's reported quarterly geoaccess compliance results for rural counties and 25.0 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 2021–2022 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, 2021



- The first bar in Figure 4-7 reflects a total of 92 dental results (i.e., minimum network requirement and county combinations), summarizing the percentage of members within each minimum network requirement and frontier Colorado county the PAHP is contracted to serve. Of those 92 PAHP frontier results, 55.4 percent (n=51) 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 39.1 percent (n=36) 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 minimum network requirement and rural Colorado county the PAHP is contracted to serve. Of those 108 PAHP rural results, 70.4 percent (n=76) have 100 percent access level, 3.7 percent (n=4) of the results have 90 to 99 percent access level, and 25.9 percent (n=28) 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 minimum network requirement and urban Colorado county the PAHP is

contracted to serve. Of those 56 PAHP urban results, 71.4 percent (n=40) have 100 percent access level and 28.6 percent (n=16) of the results have 90 to 99 percent access level.

Statewide Conclusions and Recommendations

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 91.3 percent of the CHP+ MCEs' reported quarterly geoaccess compliance results for frontier counties.

Table 4-5—Aggregate Percentage of Geoaccess Compliance Matches for FY 2021–2022 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
Medicaid MCOs	91.3%	86.2%	83.0%
PAHP	100%	98.1%	75.0%

To continue enhancement of its network adequacy oversight, the Department directed HSAG to modify the FY 2021–2022 quarterly network adequacy reporting materials to align with network needs that support ongoing service enhancements and network adequacy oversight.

Various factors associated with the FY 2021–2022 NAV may affect the validity or interpretation of the results presented in this report, including, but not limited to, the following analytic considerations and data-related caveats:

- HSAG validated the MCEs' self-reported time and distance geoaccess compliance results, reflecting the network categories and corresponding practitioner, practice site, or entity attributions.
  - Each MCE's network may include practitioners, practice sites, and entities that support additional healthcare services covered by Colorado's Health First Colorado or CHP+ programs.
  - The MCEs must demonstrate that 100 percent of their members reside within the minimum network requirements to be found in compliance with the network contract requirements. As a result, an MCE's failure to meet a time and distance network requirement does not necessarily equate to a network concern, and the MCE may have alternate methods of ensuring members' access to care (e.g., the use of telehealth or mail-order pharmacy services).
- NAV findings are associated with the MCEs' network data files for all practitioners, practice sites, and entities active with each MCE as of December 31, 2021, and are contingent on the quality of member and network data supplied by the MCEs. Any substantial and systematic errors in the MCEs' member data, network data, and/or geoaccess compliance reporting submissions may compromise the validity and reliability of the FY 2021–2022 NAV results, including the following detailed considerations:

  - NAV results do not reflect the MCEs' network changes implemented since January 2022.
  - HSAG and the Department directed the MCEs to use the Department-approved Network Crosswalk from September 2021 when preparing network data. A lack of compliance identified during the NAV analyses may reflect either a lack of contracted practitioners, practice sites, or entities for the specified MCE, or an MCE's challenges in aligning internal network data with the Department-approved Network Crosswalk categories.
  - For alignment with the MCEs' geoaccess compliance reports, HSAG primarily used the member county attributions noted in the MCEs' data for the NAV analyses. If an MCE's data were missing the member's county, HSAG used the Quest Analytics Suite to identify the member's county of residence for records with an exact address match to the geocoding resource (i.e., the address could be matched to a specific latitude and longitude). Consistent with the Department's instructions to the MCEs, HSAG's NAV analyses applied the rural minimum network requirements to the urban counties with rural areas (i.e., Larimer, Mesa, and Park counties).
  - HSAG's NAV analyses used members' residential addresses and network service addresses as supplied in the MCEs' data, and addresses may not reflect members' actual place of residence or service locations available to offer on-site services.
  - It was beyond the FY 2021–2022 NAV scope to evaluate the accuracy of the MCEs' network data against an external requirement (e.g., using telephone survey calls to verify the accuracy of network locations, contact information, new patient acceptance, or services offered).
- The time and distance calculations reflected in the FY 2021–2022 NAV represent a high-level measurement of the similarity of the geographic distribution of network locations relative to members. These 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 Health First Colorado or CHP+ programs.
  - It is likely that network locations are contracted to provide services for more than one MCE. As such, time and distance results highlight the geographic distribution of a network for all available network locations noted in the MCEs' network data files, without considering potential barriers to new patient acceptance or appointment availability at individual service locations.
  - Prior to calculating time and distance results, HSAG geocoded the MCEs' network and member data to assign latitude and longitude values to each record. A limited percentage of records could not be geocoded and were subsequently excluded from NAV analyses.
  - The MCEs' address data may not always reflect a member's place of residence (e.g., use of post office boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

Promising Practices and Opportunities for Improvement

Based on the FY 2021–2022 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 MCEs' 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. In FY 2021–2022, HSAG introduced the NADIV process and data display dashboard to enhance the thoroughness of quarterly data quality review. The NADIV dashboard provides an assessment of missing and invalid values in submitted network adequacy data files and makes comprehensive, interactive initial data quality results on network standard compliance directly accessible to the MCEs and the Department.
  - The MCEs' network data quality could be further enhanced by cross-referencing against the Department's *interChange* data[4-6] to confirm MCE practitioner network NPIs, practitioner identification values, practitioner addresses, and taxonomy codes to determine the extent to which each MCE's network aligns with the practitioner/practice site/entities enrolled in *interChange*.
- **Enhance Network Oversight Processes**: The Department has demonstrated significant growth in its oversight of the MCEs' networks through the development and implementation of standardized quarterly network adequacy reporting materials. HSAG performed analysis comparing current and alternate minimum network requirements to evaluate the appropriateness of the minimum network requirements in the MCEs' contracts with the Department. HSAG provided the results of this analysis in the CANVAS web-based dashboard, which reflected the impact of changing minimum network requirements by MCE.

  During FY 2021–2022, the Department and HSAG collaborated to generate draft versions of a formal network exception policy and request templates. The Department may consider continuing the development and implementation of these materials to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards. Future enhancements may include, but are not limited to, the following:
  - The Department may consider the extent to which the MCEs offer alternate service delivery mechanisms to ensure members' access to care if the MCEs are not able to meet the current geographic access standards. For example, the Department may consider the extent to which an MCE offers and ensures that members are able to use telehealth modalities to obtain BH services when practitioners are not available in rural or frontier counties.

[4-6] *interChange* is the Department's MMIS. All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs. While *interChange* offers a direct alignment with the Network Crosswalk for selected network categories, not all network categories are directly identified from the interChange data fields.

  - The Department may consider the incorporation and utilization of claims and encounter data in its assessment of network adequacy based on population need. The current network standards apply time and distance standards based on different practitioner types but may not capture the full picture of network adequacy to meet the needs of the population. The use of historical claims and encounter data to identify historic population needs and utilization, and applying the knowledge to the development of standards that more closely align with population needs would provide the Department, the MCEs, and Medicaid members with networks better structured to provide appropriate and adequate care. Additionally, the Department may consider establishing other alternative metrics for measuring population need and determining network adequacy based on need that may be applied to future assessment and adjustments of network adequacy standards.

- **Enhance Network Adequacy Assessment**: To further assess network adequacy, the Department may integrate specified data review topics into network adequacy analysis and an expansion of the NAV dashboard to reflect specific initiatives and goals. Future enhancements may include, but are not limited to, the following:
  - In addition to the number of practitioners accepting Medicaid members, the Department may consider asking the MCEs to submit practitioner panel capacity data indicating the number of Medicaid members they are able or willing to accept for treatment to better assess the adequacy of the network in meeting healthcare needs for enrolled Medicaid members. While the geographic distribution of practitioners is assessed through time and distance standards, the analysis does not account for whether or not those practitioners have the capacity to serve the number of Medicaid members in the respective catchment areas. Further consideration of practitioner panel capacity would allow for a better understanding of network adequacy in terms of capacity to serve members.
  - When analyzing network adequacy, it is important to consider that the list of network practitioners' physical locations may not accurately or completely represent an enrolled member's access to services. The Department may consider conducting additional analyses such as using claims and encounter data to identify which of the MCEs' network of practitioners are actively providing services to members during the measurement period. To the extent that contracted practitioners are not actively serving Medicaid members, the time and distance analyses based on the list of contracted practitioners may not be an accurate reflection of the network as experienced by Medicaid members. Future access to care evaluations may incorporate the MCEs' claims and encounter data to assess members' utilization of services and potential gaps in access to care associated with inactive practitioners in the network.
  - The Department may consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population need. To the extent that current network standards take into account the population need for different practitioner types, the standards may not capture the full picture of network adequacy to meet the needs of the population. The use of historical claims and encounter data to identify population needs and utilization, and application of that knowledge to the development of standards that more closely align with population needs would provide the Department, the MCEs, and Medicaid members with networks better structured to provide appropriate and adequate care. Additionally, the Department may establish

alternative metrics for measuring population need and determining network adequacy based on need that may be applied to future assessment and adjustment of network adequacy standards.

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 2021–2022 MCO-level and statewide aggregate rate results for each CAHPS measure.[4-7]

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

Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Aggregate Score
Rating of Health Plan	67.1%	63.7%	61.3%	62.7%	70.3%	67.5%
Rating of All Health Care	64.0%	65.1%	55.4%+	69.7%	66.5%	65.7%
Rating of Personal Doctor	74.5%	77.7%	65.5%	78.9%	73.3%	75.3%
Rating of Specialist Seen Most Often	60.8%+	63.6%+	78.0%+	70.7%+	76.9%+	65.5%
Getting Needed Care	82.5%	68.0%+ ↓	85.7%+	80.4%+	88.7% ↑	82.9%
Getting Care Quickly	83.9%	76.8%+ ↓	90.6%+ ↑	80.3%+	93.3% ↑	84.5%
How Well Doctors Communicate	97.1% ↑	94.3%+	91.1%+ ↓	97.9% ↑	95.4%	96.8%
Customer Service	91.6%+	82.9%+	78.9%+	85.9%+	89.7%+	90.4%

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

Statewide aggregate scores are added for reference.

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

[4-7] 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 member-perceived QOC and services the CHP+ MCOs received compared to the statewide aggregate.

- Four of the five MCOs showed statistically significantly higher differences:
  - COA
  - FHP
  - Kaiser
  - RMHP
- Two of the five MCOs showed statistically significantly lower differences:
  - DHMP
  - FHP
- Three of the eight measures showed statistically significantly higher and lower differences:
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
- COA did not score statistically significantly lower than the statewide aggregate for any measure but did score statistically significantly higher than the statewide aggregate for one measure:
  - *How Well Doctors Communicate*
- DHMP did not score statistically significantly higher than the statewide aggregate for any measure but did score statistically significantly lower than the statewide aggregate for two measures:
  - *Getting Needed Care*
  - *Getting Care Quickly*
- FHP scored statistically significantly higher than the statewide aggregate for one measure:
  - *Getting Care Quickly*
- FHP scored statistically significantly lower than the statewide aggregate for one measure:
  - *How Well Doctors Communicate*
- Kaiser did not score statistically significantly lower than the statewide aggregate for any measure but did score statistically significantly higher than the statewide aggregate for one measure:
  - *How Well Doctors Communicate*
- RMHP did not score statistically significantly lower than the statewide aggregate for any measure but did score statistically significantly higher than the statewide aggregate for two measures:
  - *Getting Needed Care*

  - *Getting Care Quickly* 

To address low CAHPS scores, HSAG recommends:

- The Department:
  - Collaborate with each MCO to develop initiatives designed to improve processes that may impact members' perceptions of the quality of, timeliness of, and access to care.
  - Determine if any best practices of the MCOs that scored statistically significantly higher than the statewide aggregate on certain measures can be shared with the MCOs that scored statistically significantly lower on those measures. Determine if successful interventions or actions may be duplicated to improve measure scores.
- DHMP and FHP conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received, as applicable, to determine what could be driving lower scores compared to the statewide aggregate and implement appropriate interventions to improve the performance related to the care members need.
- FHP explore provider processes that may be contributing to low experience scores for *How Well Doctors Communicate* and develop initiatives designed to improve performance including:
  - Communications programs for providers or care reminders to encourage timely requests for services by the members.
- The MCOs:
  - Evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters.
  - Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

For additional information about CHP+ CAHPS activities and results for FY 2021–2022, 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 FY 2020–2021 Recommendations

Colorado Access

Validation of Performance Improvement Projects

COA successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, COA developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

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

- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, COA continued to utilize HRAs to identify members that may benefit from outreach from care managers to establish a PCMP, complete well-child visits, and access appropriate screenings. If needs are identified on the HRA, care managers provide members/guardians with appropriate resources if there are questions or concerns surrounding nutrition and/or physical activity and encourage the member/guardian to follow-up with their provider to discuss concerns and options. Additionally, in June 2022, a well-child visit digital engagement program was launched to educate parents/guardians of the importance of well-child visits as it pertains to their health. Parents/guardians of CHP+ members receive call, text, or mailer information (based on communication preference) regarding important reminders to schedule well-visit appointments or resources to find a PCP.
- For the *Chlamydia Screening in Women* measure, COA continued to utilize HRAs to identify members that may benefit from outreach from care managers to establish a PCMP; complete well-child and/or OB/GYN visits; and access age-appropriate screenings, including chlamydia screening. In June 2022 a well-child visit digital engagement program was launched to educate parents/guardians of the importance of well-child visits as it pertains to their health.

Parents/guardians of CHP+ members receive call, text, or mailer information (based on communication preference) regarding important reminders to schedule well-visit appointments or resources to find a PCMP.

- For the *Follow-Up Care for Children Prescribed ADHD Medication* measure and the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, COA continued to utilize HRAs and the BH Care Management program to assist members prescribed medication(s) that involve more frequent provider monitoring. These programs assist members by providing resources regarding medication management, ensure follow-up appointments are scheduled and attended, and ensure questions regarding medication management for ADHD medications or antipsychotics are answered by the prescriber or pharmacist.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions:

- COA was required to develop and maintain a procedure for testing that its providers search website information complies with Section 508 specifications for accessibility.
- COA was required to ensure that any expression of dissatisfaction, except in response to a notice of adverse benefit determination (NABD), is treated as a grievance and investigated and resolved in accordance with COA's regular grievance procedures; and update the provider manual to include accurate information regarding grievance and appeal systems, specifically timelines and State fair hearing (SFH) information.
- COA did not have any required actions for Standard VII—Provider Selection and Program Integrity and Standard IX—Subcontractual Relationships and Delegation.
- COA submitted the final CAP documents in November 2021 and, following the Department's approval, completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- COA seeks opportunities to expand the care network to ensure adequate network providers and access to care. COA continued to use various resources to further target potential additions and grow the network of providers. COA had a dedicated provider contracting team that responded to inquiries and requests to participate in the network.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, COA reported engaging in the following QI initiatives:

- Identified opportunities to improve member experience through the collection and analyzation of data received from a third iteration of a qualitative member satisfaction survey that was administered through the quality department, which encouraged members to share what was important to them in terms of health services, how care could be improved, and where they typically received health information. These opportunities included improving COA's member-facing side of the website, provider directory, network maintenance processes, and the new member enrollment booklet.
- Continued the customer service quality monitoring program, including continuous monitoring of net provider scores (NPS), which also resulted in increased interdepartmental collaboration on QI projects, an improved understanding of member experience, and increased engagement from customer service representatives who participated in member-facing work daily.
- The quality department utilized the Colorado Access Member Advisory Council to gather feedback on survey questions, engage members, address gaps in the survey, and provide members with data around member experience before implementing the fourth iteration of the member survey in collaboration with the customer service department.

Denver Health Medical Plan, Inc.

Validation of Performance Improvement Projects

DHMP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, DHMP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

To improve its rates from the previous fiscal 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 chronic disease management, prevention, screening, annual visits. Workgroups were established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated BH, transitions of care, immunizations, and ambulatory care Quality Improvement Committee (QIC).
- DHMP partnered in a collaborative work process with the QI director of ACS and ACS QI staff to build joint QI interventions, including shared data analytics.
- DHMP continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS scores.
- DHMP continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores.
- DHMP increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- For measures related to well-child visits, EPSDT, and immunizations, DHMP implemented the following:
  - Ongoing efforts continue for wraparound services outside of the health plan, and for tracking of referrals for services outside the 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 two through 19 years 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 also includes how to schedule a well-child appointment. For FY 2021–2022, DHMP mailed an average of 1,670 birthday cards a month to Medicaid Choice members and an average of 122 birthday cards a month to CHP+ members.
- EPSDT outreach conducted by the health plan will continue throughout state fiscal year (SFY) 2022–2023 and remain a powerful way to identify members in need of screenings and services.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions:

- DHMP was required to update the member handbook to clarify procedures and timelines that apply to appeals and SFHs.
- DHMP was required to develop mechanisms to address all expressions of dissatisfaction received by members about any matter other than an adverse benefit determination, ensure staff members are trained to identify and process grievances and appeals, and update information in the grievance resolution letter to exclude the appeal and SFH attachments.
- DHMP was required to revise subcontracts to include all required language.
- DHMP was required to develop mechanisms to ensure that CHP+ services are verified regularly and expand sampling methodology to all CHP+ members, not only adults.

DHMP submitted the final CAP documents in November 2021. Following the Department's approval, DHMP completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- To support providers, DHMP developed and implemented a provider portal. The portal allowed the provider direct and immediate access to their information, including but not limited to benefits, member eligibility, accumulators, claims inquiry (submission, replace, void), referral/authorization inquiry (submission, review), and secure messaging.
- DHMP engaged the Department's staff members in conversations around challenges with members that resided outside of the DHMP service area. DHMP's membership profile regularly included roughly 300 members that resided outside of the DHMP service area and roughly 800 members that had addresses outside of Colorado.

- DHMP subcontracted the BH capitated program to COA including the requirement to build and maintain a sufficient network.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, DHMP reported engaging in the following QI initiatives:

- Continued to improve communication with clinics about health plan QI initiatives, including education about health plan CAHPS scores.
- Increased member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Implemented focused member outreach and care management to facilitate care transitions when acuity of need was identified.
- Increased the types of appointments (e.g., vaccines, school-based health centers [SBHCs]) that can be scheduled using MyChart.
- To address *Getting Needed Care* and *Getting Care Quickly*, Denver Health and Hospital Authority (DHHA):
  - Worked to provide greater appointment availability by expanding capacity, hours of operation, and specialty services.
  - Worked to expand access to care across numerous clinics and specialties including telemedicine.
  - Improved communication options by allowing established patients to message their PCP and care team and schedule primary care visits through Epic MyChart.
  - Escalated care by triaging calls when medically necessary through the DHHA appointment center.
  - Continued to have a 24-hour nurse line for members when the appointment center is closed and when members describe experiencing specific symptoms.
- Focused on improving consistent access to care through a delivery network that builds relationships and results in increased satisfaction with the healthcare system and better health outcomes for the population.
- Implemented a provider open shopper process by utilizing an external vendor to contact providers to request appointment availability for different types of services in an effort to monitor the networks' ability to have timely access to services.
- To address *Customer Service*, the Health Plan Customer Service (HPCS) team:
  - Provided real-time training for staff members regarding member service call QI.
  - Reviewed calls from every staff member.
  - Performed on-the-spot evaluation and training.
  - Discussed HPS phone audit report results bimonthly at the DHMP QMC.

- Worked with the member services department to develop a work plan that will assist in identifying process improvement and staff training opportunities after tracking reasons that members cite for not getting the help or information they needed.
- Worked collaboratively with ACS clinics, providers, and committees to improve the referral process, including:
  - Working directly with the provider relations team to clearly communicate the different requirements for referral timeliness within the provider network.
  - Performing a quality review of the cases regularly to determine if there are any QOCCs related to potential delays in care.
  - Participating in collaborative meetings with DHHA such as the Medical Neighborhood Committee and Care Coordination Collaborative to facilitate, collaborate, and problem solve referral issues.
- Performed a health needs assessment of all new members to understand the full spectrum of members' concerns and needs related to physical and BH as well as SDOH and communicated the results to the care coordination team, who followed up with the member through a direct phone call to provide general information and resources including community-based organizations, referrals, connection to a medical home, and general support.
- Continued to utilize a risk stratification tool to monitor and analyze the membership's health and needs to allow a targeted outreach to members that provides the education and resources related to specific conditions or issues (e.g., high number of ED visits).

Friday Health Plans of Colorado

Validation of Performance Improvement Projects

FHP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, FHP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

Since the FHP contract ended June 30, 2022, the MCO did not submit follow-up on the prior year's recommendations.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions:

- FHP was required to develop a mechanism to ensure member informational materials are easily understood, ensure key definitions in the member handbook are consistent with the Department's definition, update taglines in critical member materials, ensure the FHP website follows Section 508 guidelines, and update provider directories to include required information regarding accommodations for members with physical disabilities.
- FHP was required to clarify information in the member handbook regarding the definition of an NABD and instances when a member may appeal a denial; correct time frames regarding grievance, appeal, and SFHs in all relevant documents; update letter templates to include correct timelines and procedural information; ensure that complaints are treated as grievances; clarify that there is only one level of appeal and how a member exhausts their appeal procedures if FHP fails to adhere to appeal time frames; implement mechanisms to monitor the timely resolution of grievances and appeals, including details in member letters regarding extension timelines; inform the member of

their right to file a grievance if they do not agree with the extension; update expedited appeal timelines; and ensure accurate documentation of grievances and appeals.

- FHP was required to develop additional training and education requirements for the compliance officer and compliance staff members; ensure staff members understand the need for prompt referral of fraud, waste, and abuse issues; develop a method to sample if member services that were billed were received by the member; and create and implement a procedure to outline how FHP provides disclosures of ownership as well as prohibited affiliation information to the Department.
- FHP was required to update its contracts to ensure delegation agreements specify the delegate's activities or obligations and related reporting responsibilities; and ensure contracts include the provision related to State, CMS, and U.S. Department of Health and Human Services Office of Inspector General rights to audit.

FHP partially completed the FY 2020–2021 CAP by the time of the FY 2021–2022 compliance review, resulting in an ongoing CAP. However, with the exit of FHP from the CHP+ market in Colorado as of FY 2022–2023, the Department did not require FHP to complete the FY 2020–2021 CAP.

Validation of Network Adequacy

Since the FHP contract ended June 30, 2022, the MCO did not submit follow-up on the prior year's recommendations.

CAHPS Survey

Since the FHP contract ended June 30, 2022, the MCO did not submit follow-up on the prior year's recommendations.

Kaiser Permanente Colorado

Validation of Performance Improvement Projects

Kaiser successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, Kaiser developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

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

- Kaiser implemented outreach and reminder activities to improve post-pandemic pediatric well visit adherence and pediatric immunization rates in the CHP+ population. An automated well visit reminder program was implemented for all kids ages birth through 36 months and Kaiser will expand the activities to other ages in 2022.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions:

- Kaiser was required to implement a process to regularly review documents and simplify language, where possible, to ensure materials are easily understood; ensure a five-business-day response time for member information paper document requests; and develop a process for regular testing of PDF documents available to members to ensure these documents meet accessibility requirements and Section 508 compliance.
- Kaiser was required to update member-facing information to include the complete CHP+ definition of "adverse benefit determination," clarify that CHP+ members may file a repeat grievance without

restriction, develop a mechanism to ensure grievance resolution language is at or near the sixth-grade reading level to the extent possible, ensure accurate timelines for requesting an appeal are included in member communications, develop a mechanism to ensure appeal acknowledgement letters are sent in accordance with timeliness standards, update internal procedures and ensure oral appeals are pursued as appeals, ensure member communications related to the denial of an expedited resolution of an appeal accurately describe the applicable time frame, inform the member of the right to file a grievance if the member disagrees with the decision to deny the expediated appeal request; update documents related to continued benefits during an appeal and SFH to clearly describe applicable criteria and timeliness.

- Kaiser was required to update documents to clarify that the member must request both the continued benefits and SFH within 10 days after an appeal resolution is not in the member's favor.
- Kaiser was required to clarify the terminology "denied appeal" is an "appeal resolution not in favor for the member"; and update the provider manual and any related documents to comprehensively and accurately inform providers about the grievance, appeal, SFH, and continuation of benefits rights, timelines, and procedures.
- Kaiser was required to amend the delegation agreements with MedImpact, University Physicians, Inc. (UPI), and Memorial to include all required language.

After the time of the original report, continuation of benefits was removed from the CHP+ FY 2021–2022 contract; therefore, during the CAP process, Kaiser did not need to complete the related required action.

Kaiser submitted the final CAP documents in November 2021. Following the Department's approval, Kaiser completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- Kaiser will continue to work to address discrepancies in the service area shown online.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, Kaiser reported engaging in the following QI initiatives:

- Communicated to providers and staff members when it is CAHPS survey season to improve response rates.
- Built quality goals into provider incentives and rated providers so they can see how they perform in comparison to their peers to improve the member experience and how well providers communicate.
- Provided patient-centered training to teach providers more about patient communication and active listening, and diversity, equity, and inclusion training for all providers and staff.

- Began SDOH screening for members to help identify any critical needs that may not be present otherwise.
- Improved the readability of the CHP+ member handbook to improve the member experience.
- Increased the ways that members can access their providers by offering the following:
  - 24/7 video visits on demand
  - Chat with a provider
  - Clinical advice line
  - Ability to schedule more visits online and have more same-day access options
- Continued to improve the alerts for staff and providers to remind members to schedule preventive care tests and appointments.
- Started a wellness visit reminder campaign to directly outreach members.
- Actively monitored appointment access to help manage and improve wait times for members.
- Continuously monitored performance measures and managed resources to improve performance through member services and the clinical contact call centers.
- Currently implementing a new pediatric member advisory council to gather more feedback from members.

Rocky Mountain Health Plans

Validation of Performance Improvement Projects

RMHP successfully addressed HSAG's recommendations for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP from the previous fiscal year by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, RMHP developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

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

- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, mailing activities included:
  - Annual Wellness (CHP+ and Prime): Incentive and educational mailing brochures sent to members 3–17 years of age that include 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 interactive voice response (IVR) and postcard mailing for RAE, CHP+, and Prime members who are due for their one-year-old well visit.
  - Pediatrics Integrated Quality Workgroup (IQWg) focuses on interventions for the pediatric population. A focused measure in this group includes *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*.
  - Well-child visits (WCV) for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - July 2021 music on hold (MOH) topic was WCV for kids that played on member customer service lines for all LOB.
  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.

  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having an SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
  - Website provider tools—RMHP CPGs are posted for reference.
- For the *Prenatal and Postpartum Care* measure, activities included:
  - Maternity and Women's Care IQWg focuses on interventions for women's health. A focused measure in this group is *Prenatal and Postpartum Care*.
  - RMHP care management implemented an outreach program for high-risk pregnant members. RMHP offers the member case management and assistance finding resources.
  - RMHP s partners with WellHop, offered exclusively to RMHP CHP+, RAE, and Prime members. Through this program, expectant moms can receive additional support during their pregnancy and postpartum along with other moms with similar delivery dates to share concerns, excitements, challenges, and wins.
  - RMHP partners with SimpliFed to provide unlimited support through telemedicine for RMHP CHP+, RAE, and Prime members. SimpliFed is an organization that provides access to certified lactation specialists for new moms needing support with breastfeeding, pumping, formula feeding, or a combination.
  - Prenatal care was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of May 2022.
  - Prenatal educational message was posted to the member and provider portals during the month of May 2022.
  - Prenatal care MOH message played during the months of April through June 2022 on member customer service lines for all LOB.
  - *Provider Insider Plus* (January 2022 edition)—included a link to RMHP CPGs.
- For the *Asthma Medication Ratio* measure, activities included:
  - Diabetes and Chronic Conditions IQWg focuses on interventions for members with diabetes and chronic conditions. A focused measure in this group is *Asthma Medication Ratio*.
  - Respiratory (inhalers for chronic obstructive pulmonary disease [COPD]/asthma) is one of the disease states included in the retrospective drug utilization program.
  - Website provider tools—RMHP CPGs are posted for reference.
- For the *Childhood Immunization Status* measure, mailing activities included:
  - New Baby Packet (CHP+ and Prime): Educational brochures mailed to the member's parent or guardian at one month of age. Mailings include education on child safety, recommended immunizations by age 2, and promote child's health and safety through routine well-child checks.
  - Child's First Birthday (CHP+ and Prime): An educational brochure is 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 (CHP+ and Prime): 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 IVR and postcard mailing (RAE, CHP+, and Prime): Children who missed an immunization between 6–18 months of age receive a postcard mailing and IVR call.
  - Annual care management newsletter includes information referencing Colorado Immunization Information System (CIIS) database.
  - Pediatrics IQWg focuses on interventions for the pediatric population. A focused measure in this group is *Childhood Immunization Status*.
  - Website provider tools—RMHP CPGs are posted for reference.
  - *Provider Insider Plus* (January 2022 edition)—includes a link to RMHP CPGs.
  - WCV for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - Immunizations for children and adolescents MOH message played during the months of January through March 2022 on member customer service lines for all LOB.
  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.
  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having an SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
- For the *Immunizations for Adolescents* measure, mailing activities included:
  - Wellness that Rewards—Pre-Teen Wellness (CHP+ and Prime): Incentive and educational mailing brochure sent to members 10–13 years of age through which the member is eligible to receive a gift card upon completion of an annual wellness visit.
  - Wellness that Rewards—Immunizations for Adolescents (CHP+ and PRIME): Incentive and educational mailing brochure sent to members who turned 12 years of age annually through when the member is eligible to receive a gift card upon completion of receiving all three: Tdap, HPV, and meningococcal vaccines.
- For the *Immunizations for Adolescents* measure, other activities included:
  - Monthly postcard mailing (RAE, CHP+, and Prime): Monthly postcard mailing for adolescents who missed an immunization between 16–18 years of age.
  - HPV vaccine email sent November 2021 to the parents/guardians of members 9–13 years of age on the importance of receiving and completing the HPV vaccine series. RMHP created and

added an HPV vaccine educational landing page on the rmhp.org website. The email includes a link to RMHP's HPV vaccine landing page.
  - Pediatrics IQWg focuses on interventions for the pediatric population. A focused measure in this group includes *Immunizations for Adolescents*.
  - Website provider tools—RMHP CPGs are posted for reference.
  - *Provider Insider Plus* (January 2022 edition)—includes a link to RMHP CPGs.
  - WCV for kids was the social media message topic posted on Twitter, Pinterest, and Facebook during the month of July 2021.
  - Immunizations for children and adolescents MOH message played during the months of January through March 2022 on member customer service lines for all LOB.
  - Annual EPSDT audit for RAE and Prime members 0–20 years of age. Internal quality audit of WCV for RAE and Prime members 0–20 years of age.
  - Quarterly and annual SHCN audit for CHP+, RAE, and Prime members 0–20 years of age. Internal quality audit of CHP+, RAE, and Prime members 0–20 years of age identified as having an SHCN.
  - *Preventative Pediatric Care: Optimizing Well Child Visits in Family Practice* educational webinar by Dr. Katie Price offered to providers in February 2022.
- For the *Ambulatory Care* measure, activities included:
  - CirrusMD is available to RMHP RAE, Prime, and CHP+ members free of charge. It is a text-based virtual care platform that allows members to connect with a real healthcare provider in seconds, 24/7.
  - Adults' access to preventive/ambulatory health services is a focused measure of the Unattributed Members Workgroup and Preventative and Older Adults IQWg.
  - Annual wellness checklist was sent to providers in the June *Provider Insider Plus* newsletter.
  - RMHP launched an eConsult initiative in Mesa County. The goal of this program is for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc. This eConsult project supports general satisfaction with providers because it may reduce referrals to specialists with long wait times, empower the primary care practice, and increase education/clinical pathways within primary care. This project will be expanding in FY 2022–2023.
- For the *Follow-Up Care for Children Prescribed ADHD Medication* measure, activities included:
  - Pediatrics IQWg focused on interventions for the pediatric population. A focused measure in this group includes *Follow-Up Care for Children Prescribed ADHD Medication*.
  - Clinical Quality Improvement (CQI) team created an educational one-pager for providers on follow-up care for children prescribed ADHD medication.
  - RMHP met with practices during the pediatric medical home forum to present a list of their patients to start working on this measure.

- For the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, activities included:
  - Pediatrics IQWg focuses on interventions for the pediatric population. *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing–Total*, and *Blood Glucose and Cholesterol Testing—Total* are some of the focused measures in this group.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions:

- RMHP was required to revise the continuation of benefits description in the CHP+ Benefit Booklet to include the 10-day time frame to request continuation of benefits and clarify that the statement "the original approval must not have expired" applies only to appeals. (After the time of the original report, continuation of benefits was removed from the CHP+ FY 2021–2022 contract; therefore, during the CAP process, RMHP did not need to complete this required action. However, RMHP was required to remove references to CHP+ continuation of benefits).
- RMHP was required to develop specific criteria for defining provider appeals and member appeals.
- RMHP was required to update the member liability language in the provider manual to accurately address the various LOB that may have variations in copay and liabilities.
- RMHP was required to update the delegated credentialing agreements to include required language.

RMHP submitted the final CAP documents in January 2022. Following the Department's approval, RMHP completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- RMHP verified its data with providers regularly, including provider surveys and attestations. The data sources for both the quarterly network report (NAV) and online directory were the same, but both reflected a moment in time of data that was continually updated. Additionally, the online directory was managed in a manner to present the information for a consumer audience, thus could reflect provider preferences such as individual versus practice listings. The NAV report was managed in a manner to reflect the requirements of the template.

CAHPS Survey

To follow up on recommendations related to FY 2020–2021 CAHPS, RMHP reported engaging in the following QI initiatives:

- Implemented a process to notify provider relations, who followed up with the provider, and the Value Based Contracting Review Committee (VBCRC) when customer service was informed by members that a healthcare provider was not accepting new patients or was requiring applications for acceptance.
- Educated members on the importance of having a primary care relationship with a PCP during welcome calls and offered to help members find a PCP if they did not have one.
- Promoted CirrusMD, a telehealth platform for members to access clinicians in real time, through mailers and emails, the addition of QR codes to existing mailers, and business cards for care coordinators and external stakeholders to distribute.
- Increased provider awareness of the CAHPS survey and encouraged PCPs to deliver high-quality, patient-centered care through the discussion of a CAHPS educational video series with practices and the distribution of the video on the RMHP website.
- Included member experience topics (e.g., leadership training, BH skills training, care management training, MA skills and training, telehealth visits) in newsletter articles, learning collaborative events, and webinar series.
- Provided cultural competency training and BH skills training for providers.
- Launched an eConsult initiative in Mesa County for primary care clinicians to send a consult to specialists via a platform in order to treat the patient in primary care, send an appropriate referral, etc., which may reduce referrals to specialists with long wait times, empower the primary care practice, and increase education/clinical pathways within primary care.
- Offered several programs, tools, and resources to help practices implement QI initiatives that aim to improve member outcomes on several high-priority measures so members will be well received by providers and can be sustained long term through the CQI team in collaboration with Integrated Quality Workgroups.

DentaQuest

Validation of Performance Improvement Projects

DentaQuest successfully addressed HSAG's recommendations for the *Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year* PIP from the previous fiscal year, by documenting evidence of the following activities:

- Reviewing and updating the key driver diagrams to include any newly identified interventions and/or drivers, incorporating knowledge gained and lessons learned through the intervention determination process.
- Identifying 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 was tested for the PIP, DentaQuest developed a methodologically sound testing plan including steps for carrying out the intervention and timely and meaningful intervention effectiveness data collection and analyses.

Validation of Performance Measures

Since the prior year was the first year that DentaQuest was required to report measures, HSAG did not have any recommendations. Therefore, DentaQuest did not have any follow-up based on prior year recommendations.

Assessment of Compliance With CHIP Managed Care Regulations

For the standards reviewed in FY 2020–2021 (Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Selection and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation), HSAG identified opportunities for improvement that resulted in the following required actions for DentaQuest:

- Update taglines and font sizes in the member handbook and welcome letter; develop mechanisms to notify members that electronic information is available in paper form without charge upon request and is provided within five business days; establish mechanisms to inform members of provider termination within 15 days of termination notice; ensure all the required member rights are listed in the member handbook and that the member rights listed on the website are consistent with the member handbook; update the member handbook to include information on continued benefits during an appeal; revise the member handbook regarding continuous benefits, clarify information on appeals, and provide time frames for filing grievances and appeals; clarify the member handbook language that the appeal process is not limited to denied claims; revise the 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; update the member handbook to include other health services that are available under the State plan and include information on how to report suspected fraud or abuse and the number to reach medical management or other departments that provide services for members.

- Develop mechanisms to ensure that all grievance resolution letters are sent within the 15-working-day resolution time frame, all appeals are acknowledged in writing within two working days of the receipt of the appeal, staff members meet the 10-working-day resolution time frame for appeals, and grievance and appeal records are accurately maintained.
- Revise its member appeals policy to include informing the member of the right to file a grievance if the member disagrees with the decision to deny the expedited appeal; clarify time frames related to NABDs and appeals; revise information regarding continuation of benefits in all relevant documents; and inform providers about the member grievance and appeal systems, and clarify information regarding the processes.
- Create and implement a procedure that outlines how it provides disclosures of ownership as well as prohibited affiliation information to the Department, and develop methods to verify whether services represented by providers are received by members.

DentaQuest submitted the final CAP documents in November 2021. Following the Department's approval, DentaQuest completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Validation of Network Adequacy

- DentaQuest did not change any processes as a result of prior year recommendations.

CAHPS Survey

DentaQuest was not required to participate in the CAHPS survey.