DENVER HEALTH MEDICAL PLAN, INC.
Medicare and Exchange Quality Improvement Work Plan

Dept. Section	Structure	Goal	Calendar Year 2025 Goal(s)	Targeted Due Date	Requirement/ Planned Activity	Objective(s)	Responsible Party	Reports To	Reporting Frequency	January	February	March	April	May	June	July	August	September	October	November	December
QI	Advisory Committees and Learning Collaboratives	**Quality Management Committee**	• Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes • Provides oversight to working subcommittees and determines final opportunities for selection for reporting requirements.	**Meets Bi-Monthly:** **1/14/2025** **3/11/2025** **5/13/2025** **7/8/2025** **9/9/2025** **11/11/2025**	**• Analyzes and evaluates the results of QI activities** **• Ensures practitioner participation in the QI program through planning, design, implementation or review** **• Identifies needed actions** **• Ensures follow-up, as needed**	**DHMP's Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members.**	**Chief Medical Officer (CMO)** **Interim CMO** **QI Manager** **QI Project Managers**	**QMC**	**Bi-Monthly**	x		x		x		x		x		x	
Insurance Products, MCR/HIX	Advisory Committees and Learning Collaboratives	**Member Experience Committee**	• Create an onboarding and engagement strategy that builds rapport with members early, addresses concerns immediately, tailors communication to preferences, empowers members (through integrated technology and education), and improves satisfaction • Establish metrics to monitor success of member experience initiatives • Form and maintain a member advisory committee to solicit direct input and feedback on enrollee experiences, member materials, and/or policies • Improve member experience between the member and plan • Enhance member usability and experience of plan benefits and tools	**Meets Monthly:** **• January 15, 2025** **• February 12, 2025** **• March 12, 2025** **• April 9, 2025** **• May 14, 2025** **• June 11, 2025** **• July 17, 2025** **• August 20, 2025** **• Sept 9, 2025** **• October 15, 2025** **• November 19, 2025** **• December 17, 2025**	**• Use MEC Smartsheet to review all member experience interventions.**	**DHMP's Member Experience Committee was established in Q1-24 to align with the strategic goal of creating, implementing, and continuously improving member onboarding and engagement. The committee meets monthly to review, suggest data-driven changes, and evaluate member experience. The Committee will assess policies and procedures related to member onboarding, experience and engagement, materials and usability of plan benefits.**	**Director of Member and Provider Experience** **Director of Insurance Products**	**Executive Team**	**Monthly**	x	x	x	x	x	x	x	x	x	x	x	x
QI	Advisory Committees and Learning Collaboratives	**Medical Management Committee**	DHMP's Medical Management Committee (MMC) acts as a working sub-committee to the QMC. The MMC assists the QMC in overseeing and ensuring quality of clinical care, patient safety, State/CMS/NCQA reporting requirements and program operations provided throughout the organization.	Meets Bi-Monthly: • February 11, 2025 • April 29, 2025 • June 24, 2025 • August 26, 2025 • October 28, 2025 • December 30, 2025	**The MMC is responsible for assisting the organization in providing oversight, critical evaluation, and delegation of actions and selection of opportunities while maintaining a constructive relationship with medical staff and approving/overseeing policies and procedures.**	**•Providing strong support and oversight to an initiative to improve Continuity and Coordination of Care** **•Works in collaboration with the QMC** **•Works in collaboration with the Network Management Committee (NMC)** **•Ensure all regulatory and NCQA requirements are reported in a consistent, accurate and reliable manner**	**Chief Medical Officer (CMO)** **Interim CMO** **QI Manager** **QI Project Managers**	**QMC**	**Bi-Monthly**		x		x		x		x		x		x
MedEcon/Finance	Advisory Committees and Learning Collaboratives	**Network Management Committee**	DHMP's Network Management Committee (NMC) acts as a working sub-committee to the QMC. The NMC is tasked with establishing, maintaining and reviewing network standards and operational processes.	Meets Quarterly: 3/19/2025 5/19/2025 8/18/2025 11/17/2025	The Network Management Committee is tasked with establishing, maintaining and reviewing network standards and operational processes as required by National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), Colorado Department of Health Care Policy and Financing (HCPF), and the Colorado Division of Insurance (DOI). The Network Management Committee is accountable to the Quality Management Committee (QMC).	• Review network adequacy as it relates to required availability ratios, geographical distance, and evaluate in alignment with access standards. • Develop contracting plans and reporting/tools to support data-driven network management decisions. • Oversee P&P and work related to contractual and regulatory network adequacy requirements (such as CMS, DOI, NCQA), and opportunities for improvement.	**Chief Financial Officer (CFO)** **Director of Actuary Services** **Manager of Medical Economics**	**QMC**	**Quarterly**			x		x			x			x	
QI, PH	Advisory Committees and Learning Collaboratives	**Collaborative QI Workgroups**	QI/Pop Health (PH) plan representatives participate in several collaborative workgroups in partnership with DHHA leadership, including but not limited to Ambulatory Care Services (ACS), an NCQA recognized PCMH, and universal health-related social needs (HRSN) screening workgroup.	12/31/2025	**Meets Monthly:** • Medicare Star Ratings Workgroup • Cancer Screening • Social Determinents of Health (SDOH) • Pediatric QI • Integrated Behavioral Health • Perinatal • Asthma • Transition of Care • Immunizations **Meets Ad-Hoc:** • Health Related Social Needs (HRSN) Screening	• Leverage active partnerships and collaborate in work group activities with network practitioners/providers on QI/PH interventions in chronic disease management, prevention, screening, and annual visits.	**Sr. Pop Health Manager** **QI Manager** **PH & QI Project Managers** **PH Pharmacist**	**QMC**	**As Needed**	x	x	x	x	x	x	x	x	x	x	x	x

CR	Advisory Committees and Learning Collaboratives	Credentialing Committee	DHMP's Credentialing Committee is a subcommittee of the Quality Management Committee and is responsible for evaluating DHMP contracted licensed practitioners, both physicians and non-physicians, who have an independent relationship with the plan. DHMP complies with Colorado law and current CMS requirements regarding credentialing, re-credentialing, and ongoing monitoring of practitioners. The Credentialing Committee uses active participating practitioners to provide advice and expertise in credentialing decisions.	Meets Bi-Monthly: • 1/22/2025 • 3/26/2025 • 5/28/2025 • 7/23/2025 • 9/24/2025 • 11/19/2025	Committee functions include: 1.) Review and approve the Credentialing Charter, Credentialing Policies and Procedures and Credentialing Plan 2.) Review Practitioner applications, discuss qualifications, and approve or deny the application based on DHMP established criteria 3.) DHMP Medical Director reviews all clean files and makes a determination consistent with DHMP Credentialing policies and procedures. 4.) Provide oversight of all delegated credentialing programs and activities, including but not limited to review of all applications from provider to become a delegated entity and all annual delegated audits. 5.) Responsible for review and oversight of practitioner quality of care concerns and first level of review for potential disciplinary action consistent with DHMP policies and procedures	1. Review credentials, licensure, participation status with CMS and Character of participating or potential participating providers. 2. Ensuring the review and approval of files are complete. 3. Ensuring Member safety by reviewing provider (QOC) (HAI)s(HAC) and sanctions. 4. Makes recommendation for (CAP)	CMO Interim CMO Credentialing Coordinators QI Manager	QMC	Quarterly	x		x		x		x			
PH, QI	Collection and Submission of Performance Measurement Data	HEDIS MY2024 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis	HEDIS is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS MY now has 87 measures across six (6) domains of care which allow for comparison of quality performance nationally. across health plans.	9/1/2025	**•HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures.** **•Data validation prior to submission date** **•Meet submission deadline** **•Data from the HEDIS project is analyzed to determine areas of intervention and improvement** **Reports: Validated Rates to QMC Annually**	• Continue the transition to electronic clinical data system (ECDS) reporting for the remaining measures per NCQA requirements. Evidence of annual analysis includes: • Presentation to the QMC • Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes. • Increase medical record compliance by improving coding and documentation. • To measure effectiveness of intervention; analysis will be accomplished by comparing previous year results with	HEDIS Supervisor Informatics Manager PH Manager QI Manager QI/PH Project Manager(s)	QMC	Annually								x		
PH	Collection and Submission of Performance Measurement Data	Improving Breast Cancer Screening	To improve HEDIS rates for the Measure Breast Cancer Screening. Every month a list will be drawn from the data warehouse, and run against claims and the active member's list. All MCD women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment.	12/31/2025	**DHMP's PH Department:** **PH will coordinate with WMC staff to post the locations and schedules of BCS screenings (mobile van (WMC)) on the Pulse and Frontlines.** **Create monthly mailing list of all MCD women 45+ years old who are due/overdue for a mammogram. PH Project Manager:** **•Conducts monthly data pull** **•Defines eligible participants** **•Distributes member list for mailing**	• MCR Current HEDIS MY 2023: 79% (4 Star) • MCR HEDIS MY2025 Goal: 84% (5 Star cutpoint)	PH QI Project Managers	QMC	Annually			x								
PH, QI	Collection and Submission of Performance Measurement Data	Improving Child and Adolescent Well Care Visits	To improve the Exchange HEDIS Rates for Child and Adolescent Well-Care Visits (WCV) for children ages 3-21.	12/31/2025	**The following interventions will be ongoing in 2025:** **•Healthy Heroes Birthday Cards mailed to all members with birthdays in that month who have not yet had an annual wellness visit •SBHC Targeted Lists** **•SBHC Enrollment Increase** **Reported: Validated Rates to QMC Annually**	Goal HEDIS MY2025 Rate: Commercial 50th Percentile	PH QI Project Managers	QMC	Annually			x				x			
A&G, ECS, UM, QI, PH	External Quality Review	Patient Safety Initiatives	The Quality Improvement Department works collaboratively with Utilization Management, Care Management, Population Health, Pharmacy, and A&G Departments to provide clinical quality monitoring and identification of performance improvement opportunities related to member safety are reviewed and implemented.	12/31/2025	The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches. **Reports:** Credentialing Committee quarterly & QMC required ad-hoc if any patient safety concerns identified through A&G. Quality of clinical care concerns are reported to Credentialing Committee, and QOC cases will route out to QMC only if Credential Committee pushes a serious case out/trends observed for additional review/reporting.	• Encourage organizational learning about medical and health care errors • Incorporate patient safety education across organization • Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee • Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result • Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions • Review and investigate serious outcomes where a patient injury has occurred or patient	Manager of QI G&A Mgr. CMO Interim CMO Pharmacy Director Sr. Manager Pop Health Director of Utilization Mgmt. Program Manager--A&G/UM	QMC	Quarterly	x			x	x				x		
Marketing	Member Experience of Care	Member Communication Requirements Upon Enrollment and Annually Thereafter	The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan.	12/31/2025	**Members are provided the following information, including but not limited to:** **• Member rights and responsibilities statement** **• Subscriber/benefit information** **• PHI use and disclosure information** **• The process for members to self-refer to case management** **• How to access staff** **• An affirmative statement about incentives** **Reports: QMC annually**	• Must provide evidence of communication to all commercial members upon enrollment and annually thereafter	Marketing Manager	QMC	Annually				x							

HPS, Marketing	Member Experience of Care	Providing Members with Information	Ensure that web, telephone, and email communications between the health plan and our members enable members to quickly find an in-network PCP, provide clear information to help members easily understand and navigate their health plan benefits, such as when prior authorization may be required and what costs they can anticipate for specific treatments or services.	Due 3/4/25 (March QMC): Annual Analysis of Member Experience with Web, Telephone, and Email Monthly HPS Q&A through 12/31/2025	**▪Collecting data on quality and accuracy of information provided.** **▪Analyzing data against standards or goals.** **▪Determining causes of deficiencies, as applicable** **▪Acting to improve identified deficiencies, as applicable** **▪Has a process for responding to member email inquiries within one business day of submission.** **▪Annually acts to improve identified deficiencies** **▪Annually collects data on email turnaround time** **▪Annually collects data on the quality of email responses** **▪Annually analyzes data**	• 90% quality and 90% accuracy for both telephone and email/web	Marketing, HPS, CM	QMC	Annually	X										
Pharmacy	Member Experience of Care	Monitoring Pharmacy Benefit Information for Quality and Accuracy	Analyze quality and accuracy (Q&A) of pharmacy benefit information provided to members telephonically and online, such as determine their financial responsibility for a drug, order a refill for an existing mail-order prescription, determine availability of generic substitutes, and locate an in-network pharmacy based on ZIP code.	Quarterly Q&A on-going through 12/31/2025 Due 3/4/25 (March QMC): Annual	Components of the process: ▪Collects data on quality of service and accuracy of pharmacy benefit information provided both telephonically and online ▪Analyzes data results ▪Acts to correct identified deficiencies. Monitored: Quarterly Reports: QMC Yearly	• Telephone: 90% quality, 90% accuracy • Online: 90% quality, 90% accuracy	Pharmacy Director Pharmacy Supervisor Pharmacy Technician Supervisor Health Plan Compliance Analyst	QMC	Annually Quarterly			x								
HPS	Member Experience of Care	Monitoring Member Services' Benefit Information for Quality and Accuracy	The Health Plan Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.	Annual analysis comes to 3/11/2025 QMC Quarterly reporting through EOY	**Components of the process:** **▪Collecting data on quality and accuracy of information provided** **▪Analyzing data against standards or goals** **▪Determining the cause of deficiencies, as applicable** **▪Acting to correct identified deficiencies** **Monitoring: Monthly** **Reported: QMC Quarterly**	• Telephone: 90% accuracy • Online: 90% accuracy	Manager Health Plan Services Health Plan Services Supervisor	QMC	Quarterly	x		x		x		x			x		
MAT, MEC, A&G, HPS, Marketing	Member Experience of Care	Assessing Member Understanding of DHMP Procedures	Various DHMP departments (including Product Lines, Marketing, and Monitoring, Auditing and Training (MAT)) have a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures, including but not limited to new member complaints and DHMP's Member Advisory Council.	**January 14, 2025** **March 11, 2025** **June 24, 2025** **September 9, 2025** **December 30, 2025**	**Assessment includes:** **▪Monitoring new member understanding of DHMP procedures** **▪Implementing procedures to maintain accuracy of marketing communication** **▪Acting on opportunities for improvement** **Reports: QMC Quarterly, MEC Ad-Hoc**	• There must be evidence of a systematic and ongoing process for assessing new-members ,understanding of DHMP operations and policies. • Identify and act on opportunities related to new member understanding of how to use their benefits and DHMP operating procedures.	Monitoring, Auditing, and Training (MAT) Manager Director of Member and Provider Experience Director of Insurance Products PLMs Marketing Manager	QMC	Annually	x		x			x			x			x
Marketing	Member Experience of Care	Member Annual Communication Requirements	The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan topics related to patient care and service.	**January 30, 2025** **September 30, 2025**	**Members receive:** **▪Information about the quality program goals and outcomes as related to member care and service** **▪Pharmaceutical restriction and preference information, including formulary.** **Reports: QMC annually**	• Must provide evidence of annual communication to all members	Marketing Manager	QMC	Annually					x						
QI, PH, Product Lines	Member Experience of Care	RY2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis	Assess member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS member satisfaction survey.	Survey window March-June 2025 Cut points received 10/30/2025 Scores received 9/1/2025 QMC Presentation 11/11/2025 Newsletter Communication 11/30/2025	**DHMP's QI Department:** **▪Sends CAHPS surveys out annually to members via random sample.** **▪Validates data before submission** **▪Meets CAHPS submission deadline** **▪Analyzes survey results to determine areas of intervention and improvement** **Reports: Final results to QMC Annually**	Evidence of annual analysis includes: ▪Presentation to the QMC ▪Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.	HEDIS Supervisor Informatics Manager PH Manager PH Project Manager QI Manager QI Project Manager	QMC, MEC	Annually							x				
CM	Member Experience of Care	Monitoring Satisfaction with Complex Case Management	Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction. Affects member experience	3/1/2025	Satisfaction data is collected through the following methods: ▪Obtaining survey feedback from members ▪Analyzing member complaints for tracking/trending Reports: MMC Annually Reports: QMC Annually	Members: 100% of the respondents will indicate 80% satisfaction with the program.	Director of Health Medical Management	QMC MMC	Annually			x								
A&G	Member Experience of Care	Monitoring Member Satisfaction	DHMP monitors member satisfaction with our services and identifies areas of potential improvement. To assess member satisfaction with our services, DHMP annually evaluates member complaints to analyze tracking and trending	12/31/2025	**Aggregate member complaints and appeals by reason, showing rates related to:** **▪Quality of Care** **▪Access** **▪Attitude and Service** **▪Billing and Financial Issues** **Reports: QMC Quarterly updates and Annually year and prior year report, MEC as needed**	Evidence of monitoring includes: ▪Annual reporting to the QMC ▪Root-cause analysis provided to identify opportunities for improvement.	Director of Health Plan Services MAT Manager A&G Manager	QMC	Annual (report) Quarterly(updates)	x				x		x			x		
QI, Product Lines, MedEcon, MAT	Member Experience of Care	Cultural and Linguistic Appropriate Services (CLAS)	To deliver culturally and linguistically appropriate services to DHMP membership.	**Policy review due 8/30/2025** **Annual NCQA network adequacy analysis: 9/30/2025**	**• Ongoing effort to reduce health disparities based on available REL data ensure appropriate literacy levels in member material and improve of REL membership data** **Reports: QMC Annually**	• Improve provision of culturally and linguistically appropriate care to members • Improve collection of REL membership and provider data	QI Project Manager Medical Economics Manager Medical Economics Analysts	QMC, NMC, DH ASC QIC	Annually								x				

UM	Quality and Appropriateness of Care Furnished to Members	Evaluating Utilization Management Criteria	Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate	12/31/2025	**DHMP's UM Department has:** • Written UM decision-making criteria that are objective and based on medical evidence • Written policies for applying the criteria based on individual needs • Involvement of appropriate practitioners in developing, adopting and reviewing criteria Reports: MMC MMC reports via Meeting Minutes to QMC	Criteria must consider at least the following when applying criteria to a given individual: •Age •Comorbidities •Complications •Progress of Treatment •Psychosocial situation •Home environment, when applicable	Director of Utilization Mgmt. Medical Director	MMC	Annually				x								
Pharmacy	Quality and Appropriateness of Care Furnished to Members	Pharmaceutical Patient Safety Issues	The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacies or practitioners. This represents an opportunity to provide added patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons.	12/31/2025	**•Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety.** **•An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall.** **•Reports: Compliance Committee Annually and MMC ad hoc**	100% Compliance for: •Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification. •Class II: Affected members and providers notified within thirty days of the FDA notification.	Pharmacy Director Pharmacy Supervisor Pharmacy Technician Supervisor Health Plan Compliance Analyst	MMC Compliance Committee Annually	Ad Hoc										
UM	Quality and Appropriateness of Care Furnished to Members	UM Dept Criteria for UM decisions	DHMP makes UM decisions in a timely manner to minimize any disruption in the provision of healthcare.	9/30/2025	**DHMP monitors and submits a report for timeliness of all requests.** **DHMP follows mental parity requirements.**	Ensure staff has evidence-based resources to assist in UM decision making.	Director of A&G/UM	QMC, UM Committees	Annually							x				
UM	Quality and Appropriateness of Care Furnished to Members	UM Dept Review of UM program	DHMP remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.	3/11/2025	DHMP monitors and submits a report for timeliness of all requests. DHMP follows mental parity requirements.	• The UM Program Description is due in March.	Director of Utilization Management	QMC	Annually			x								
CM	Quality and Appropriateness of Care Furnished to Members	Promote and improve health outcomes for D- SNP members with chronic conditions	The D-SNP beneficiary specific performance measures are collaboratively developed in conjunction with DHMP and the DHHA Ambulatory Care Quality Committee (QIC). This SNP-MOC specific set of goals reflect process, impact and outcome measures.	12/31/2025	Procedure: •DHMP Care Management Department produces an annual SNP MOC program evaluation responsible for the operations of the SNP MOC HRAT, ICP and ICT facilitation, and reporting key metrics. •The results of the MOC annual program evaluation, updated program description, and work plan will be reviewed and approved annually by the QMC •Final approval of program goal is provided by the DHMP Board of Directors •SNP MOC evaluation content is then distributed to the Denver Health Ambulatory care QI Committee (QIC)	Promote and improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT: •Improving or maintaining member physical health-73% Performance Goal •Members with all ICP Goals Completed - Initial -100% Performance Goal •Members with all ICP Goals Completed - Annual -100% Performance Goal Promote and improve health outcomes for DSNP members with chronic conditions: •Diabetes care - blood sugar controlled - 72% Performance Goal •Controlling high blood pressure - 75%	Director of Health Plan Care Management CM Operations Manager CM Clinical Manager	QMC	Annually			x								
A&G, UM, Pharmacy, Cred, QI, MAT	Quality and Compliance Monitoring Activities	UM, A&G, Pharmacy Information Integrity (formerly System Controls) Training & Oversight	Ensure required staff, including new hires, (i.e. Credentialing, Pharmacy, UM, A&G) complete information integrity training by tracking completion status in Workday Learning.	3/11/2025: Annual information integrity oversight to March QMC (CR, Rx), July QMC (A&G, UM). 12/31/2025: Existing staff and new (if any) should receive annually the information integrity training (UM, A&G, Pharmacy, and CR).	Develop and implement information integrity training. Ensure existing and new Credentialing, UM, A&G, and Pharmacy staff complete the training, at minimum annually. • Identify and analyze all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. • Act on all findings (if any) and implement a monitoring process to demonstrate improvement.	DHMP has information integrity policies and procedures in place to protect data from being altered outside of prescribed protocols, and monitor compliance for information integrity specific to UM (including A&G and Pharmacy) and Delegation Oversight for authorization, denial, appeal notification and receipt dates.	Credentialing Coordinator Pharmacy Compliance Analyst Program Manager, UM & A&G Monitoring, Auditing & Trainining (MAT) Manager NCQA Project Manager Medical Director	QMC	Annually			x			x				
CR	Quality and Compliance Monitoring Activities	Ongoing Monitoring of Network Practitioners and Providers Site Quality	Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP's office-site standards. This is achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality.	12/31/2025	**Provider Relations and Credentialing:** • Sets performance standards and thresholds for office site quality • Establishes a documented process for ongoing monitoring and investigation of member complaints related to practice sites • Reports: QMC via CC Quarterly	• Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met • Deliver corrective action plans (CAPs) within 30 calendar days of site visit • Repeat site visits are conducted six months after delivering CAPs to assure compliance	Credentialing Coordinator Manager of Marketing, Communications, Provider and Member Engagement DHMP CMO QI Manager	Credentialing Committee	Quarterly	x		x		x		x		x	
CR	Quality and Compliance Monitoring Activities	Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues	Credentialing Committee DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified.	12/31/2025	**Satisfaction data is collected through the following methods:** • Obtaining survey feedback from members • Analyzing member complaints for tracking/trending • Reports from credentialing delegates Reports: CCM bi-monthly, CCM minutes go to QMC quarterly	•Review sanction information within 30 calendar days of its release •Implementing appropriate interventions when instances of poor quality are identified	Medical Director Manager of Grievance and Appeals	CCM, QMC	CCM is bi-monthly, Minutes come to QMC Quarterly	x		x		x		x		x		x

MedEcon, QI	Quality and Compliance Monitoring Activities	Monitoring Accessibility of Services	DHMP analyzes availability, access, and member experience accessing the network as it relates to primary, high-volume specialty, high-impact specialty, prescribing behavioral health (BH), and non-prescribing BH practitioners in alignment with NCQA and DHMP Access to Care and Service Standards.	Annual analysis 9/30/2025	**Analyze availability ratios and geo-distance against standards, provider access survey results, and CAHPS performance trends in alignment with DHMP's Access policies.**	• Meet urban, suburban and rural standards set in the Access to Care and Services Policy Reports: NMC, QMC	Medical Economics Manager Medical Economics Analysts NCQA Project Manager	NMC	Annually			x		x			x	x		x		
UM	Quality and Compliance Monitoring Activities	Monitoring Consistency of Applying UM Criteria	Evaluates consistency of health care professionals making UM decisions by applying criteria consistently and appropriately as validated by annual Inter-Rater Reliability Testing for all clinical reviewers	12/31/2025	**DHMP's Utilization Management •Evaluates consistency of health care professionals making UM decisions by applying criteria consistently and appropriately** **• Acts on opportunities found in Inter-Rater Reliability testing results to assist in appropriate decision making by all clinical staff** **Reports: MMC, MMC reports to QMC via meeting minutes**	•80% Accuracy Rate for Inter-Rater Reliability Testing.	Director of Utilization Mgmt. Medical Director	MMC	Annually								x				
Pharmacy	Quality and Compliance Monitoring Activities	Monitoring of Formulary and Pharmaceutical Management Procedures	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion.	12/31/2025	**Minutes from the P&T meeting are presented and reviewed at the Medical Management Committee (MMC) on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes.**	•Must present and review all pharmaceutical management procedures annually to address areas for improvement	Pharmacy	MMC P&T	Bi- Monthly Monthly		x		x		x		x		x		x
CR, ECS	Quality and Compliance Monitoring Activities	Physician and Hospital Directory Usability Testing	At least every three (3) years (36 months), the Credentialing Department evaluates DHMP's web-based physician and hospital directory for health literacy, understandability and usefulness to members and prospective members. Obtain feedback from Member Experience Committee (MEC) and focus group initiatives (such as Coffee Talks) as it relates to provider directory search functionality with focus on specialty care.	Usability Testing Analysis due July 30, 2025 MEC ad-hoc as needed, ongoing through 12/31/2025	• Identify opportunities related to member UX locating in-network specialty practitioners/providers. • Select and act on opportunities. **Testing considers:** •Font size •Reading level •Intuitive content organization •Ease of navigation •Directories in additional languages, if applicable to membership **Testing occurs:** •When there are significant changes to member demographics •When there are changes to the layout of design of the directory Internal staff who were not involved in the development of the directory participate in testing.	• There must be a documented process describing how usability testing is performed. • There must be evidence indicating initial usability testing was performed when there were significant changes to member demographics or to the layout or design. • Assess member feedback on provider directory specialty search functionality, to determine what enhancements are needed.	Medical Director Credentialing Coordinator Marketing, Communications, Provider and Member Engagement Manager Director, Member and Provider Experience Director, Insurance Products QI Manager	QMC MEC	At least every 3 years						x				
ECS	Quality and Compliance Monitoring Activities	Monitoring Privacy and Confidentiality Safety Clinical PHI	The Compliance Department has a process for identifying, reporting and taking action on impermissible uses or disclosure of sensitive information.	12/31/2025	**The Compliance Department implements procedures for:** **•Identifying impermissible uses or disclosure of sensitive information** **•Reporting impermissible uses or disclosures of sensitive information** **•Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information**	•Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality. •If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections may include, but are not limited to: •Education and training •Process/procedural revisions •Progressive discipline	Privacy Officer	Board Of Directors	Annually					x						
HPS	Quality and Compliance Monitoring Activities	Monitoring Health Plan Services' Telephonic Performance	The Health Plan Services Department has a process for monitoring and evaluating telephonic quality and metrics against established benchmarks and thresholds.	Bring to QMC annual analysis: 3/11/2025 Bring to QMC quarterly analysis: April 2025 bring Q1-25, July 2025 bring Q2, October 2025 bring Q3, January 2026 bring Q4-25	**Reporting categories:** **• Service Level** **•Average delay to answer** **•Calls abandoned** **•Quality/Accuracy** **•Call volume Monitoring: Monthly** **Reports: QMC Quarterly**	•Service level: at or above 80% •Time to answer: 30 seconds or less •Time to answer 2 minutes or less Medicaid •Time to answer: 250 seconds or less CHP+ •Abandonment rate: 5% or less	Health Plan Services Manager Health Plan Services Supervisor Director of Member and	QMC	Quarterly	x		x		x		x			x		
CR	Quality and Compliance Monitoring Activities	Credentialing Delegation Oversight (Credentialing Audit Assessment Tool & Delegation Audit Letters)	DHMP is responsible for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities.	3/11/2025	**•Annually reviews its sub-delegate's credentialing P&Ps** **• Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect** **• Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities** **• Semiannually evaluates regular reports, as specified in Element A** **•Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors it's compliance with the delegation agreement or with the delegate's policies and procedures at least annually.** **•Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.**	Ensure consistent compliance with credentialing delegation standards by conducting annual and semiannual evaluations of credentialing processes, system security, and performance, addressing identified issues, and implementing a quarterly monitoring process to drive improvements, if discrepancies are identified for three consecutive quarters until the issue is corrected.	Credentialing Coordinator	QMC	Annually			x								x
IS, HEDIS, QI	Information Technology Infrastructure Improvement	Epic integration into clinical data reporting for ECDS capabilities	• Continue partnership with Epic and IS teams to build Epic EHR functionality to capture HEDIS quality measure data through electronic reporting.	6/30/2025	**The following list of HEDIS ECDS measures will be reported with limited data for HEDIS MY2024:** **•Breast Cancer Screening (BCS-E)** **•Cervical Cancer Screening (CCS-E)** **•Colorectal Cancer Screening (COL-E)** **•Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)** **•Prenatal Depression Screening and Follow-Up (PND-E)** **•Postpartum Depression Screening and Follow-Up (PDS-E)** **•Social Need Screening and Intervention (SNS-E)**	• Partner with the DH Epic team to adhere to NCQA reporting standards for HEDIS quality measure data collection and submission, referred to as ECDS, and to align with the industry's move to digital measures.	Quality Informatics Program Manager	QMC	Annually										X	

CR, PR, SMO	Information Technology Infrastructure Improvement	New Provider Data Management Warehouse (PDMW) Solution	• Centralize and standardize provider information, to ensure data is consistently updated and maintained, reducing discrepancies and improving the quality of the provider directory. • Enhance the accuracy and efficiency of provider data (including REL) for a health plan, particularly concerning the provider directory and claims processing.	6/30/2025	• DHMP's Strategy Management Office (SMO) serve as primary POC for implementation with vendor Gaines. • Review DHMP's policies and procedures to ensure proper data governance to define data ownership, access control, and quality standards. • Various DHMP departments, including but not limited to Credentialing and Provider Relations, to attend vendor training on system capabilities.	• Enhance the accuracy and efficency of provider data for a health plan, particularly concerning the provider directory. • Members will benefit from having access to accurate information about their healthcare providers, which streamlines the process of finding in-network services. • Change the way provider data is fed to the claims system, which will increase the accuracy of provider data, thus increase the	Credentialing Provider Relations SMO	QMC	Annually		x									
CR	Quality and Compliance Monitoring Activities	Credentialing Delegate Training	Continue delegate training on credentailing.	6/30/2025	**To update the training to include the new information New template** **Why we are asking for the information** **SMO is working on contract with Gaines** **New PDMW in June 2025** **New data points (in alignment with DOI and State requirements)**	To train delagates on the new roster templates and include an acknowledgment email required as part of the training. New data fields of cultural competency training completion status indicator, race and ethnicity (R&E), and handicapp accessibility data were added per DOI and CMS regulations.	Credentialing Coordinator	QMC	Annually							x					
CM	Quality and Compliance Monitoring Activities	Care Management Updates	DHMP developed an internal comprehensive care management program in 2021. DHMP continues to collaborate with ACS in the provision of care management and quality improvement services and programs for patients and Members. In addition, care management was identified as an area of operational excellence for Denver Health in 2018 and additional focus and resources have been allocated to help develop a comprehensive and robust care management system that spans across DHMP and ACS for seamless coverage to patients and Members. A dashboard with operational metrics is part of this initiative with regular review by leadership teams.	3/1/2025	The Care Management Department maintains a Program description and performs an annual program evaluation for CM. Each year, Care Management completes a Program Evaluation, and uses the findings in that Evaluation to evaluate and revise the Care Management Program Description. Both documents are brought to the QMC for review and approval.	•All requirements must be met •Reviewed and updated annually •Submitted for review to the QMC	Director of Health Plan Care Management CM Operations Manager CM Clinical Manager	QMC	Annually			x									
CM	Quality and Compliance Monitoring Activities	Care Management Program Description, Evaluation, and Workplan	The Care Management department maintains a program description and performs an annual program evaluation. Each year, CM completes a Program Evaluation, and uses the findings in that Evaluation to evaluate and revise the CM Program Description. Both documents are brought to QMC for review and approval.	3/1/2025	The Program Description must include: ▪Program Structure ▪How members are referred ▪Description of programs The Program Evaluation must include: ▪Review of program metrics ▪Analysis of results and barriers The Work Plan Must Include: ▪Objectives for the Care Coordination Department ▪Required or Planned Activities ▪Performance/Target Goals	▪All requirements must be met ▪Reviewed and updated annually ▪Submitted for review to the QMC and BOD	Director of Health Plan Care Management CM Operations Manager CM Clinical Manager	QMC	Annually			x									
CM, HEDIS, PH, QI	Quality and Compliance Monitoring Activities	Improve continuity and coordination (CoC) of medical and behavioral healthcare (BH) for members	Improve performance of Medicare HEDIS FUA-7 measure and Exchange QRS IET-Iniatiation of SUD measure through network collaboration with Center for Addition Medicine (CAM).	January 14, 2025 QMC voted to pursue FUA-7 for MCR and IET-Iniatiation of SUD for HIX. March 11, 2025 present PIPs to QMC. March through September 2025: Act on interventions and report out progress in committee.	**Annual identification of opportunities to improve CoC of medical and BH care by:** • Collecting data on member movement between practitioners, across settings, and care transitions • Conducting quanitative and qualitative analyses of data to identify improvement opportunities • Acting on at least one HEDIS CoC measure for Medicare and one HIX QRS CoC measure for improvement and measuring effectiveness Reports: QMC/MMC Annually	Act on interventions to improve performance on at least one Continuity and Coordination (CoC) measure for Medicare and one for Exchange in 2025.	PH Manager PH/QI Project Managers QI Manager HEDIS Supervisor Health Plan Coordinator	QMC	Annually	x		x		x		x		x			
CM, PH, QI, Pharmacy	Quality and Compliance Monitoring Activities	Improve and promote health outcomes for members with Hypertension	The controlling blood pressure program is offered to DHMP members that are identified as out of control and/or non-adherent with controlling their blood pressure. This program is in collaboration with the DH Pharmacy team and QI/Population Health Team for interventions, including a CBP pilot program to send blood pressure cuffs to Dual Eligible Special Needs members to use in-home for telemedicine visits and personal monitoring. DHMP care managers focus on referring noncompliant members to their PCP/Clinician for management while supporting the member.	12/31/2025	• Continue expanding the controlling blood pressure program by identifying eligible members using the clinical risk stratification tool and the gaps in care dashboard • Continue to support members in condition management through education, community-based referrals, and coordination of care	• Increase the percentage of members with hypertension with blood pressure under control (<140/90 mm Hg at most recent BP reading) by 1.5%	Director of Health Plan Care Management CM Operations Manager CM Clinical Manager	QMC	Annually			x									
CM	Quality and Appropriateness of Care Furnished to Members	Improve and promote health outcomes for members with Diabetes	The Diabetes Care Management Program is designed to improve quality care of Diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. DHMP collaborates with Denver Health Hospital Authority on peer and support groups and access to community programs. Care Managers assist members with accessing screening and access to behavioral health through Denver Health. Care Managers provide additional education and support to increase engagement with the healthcare system, identify changeable SDOH and decrease inequities in care and access to mental health for diabetic members.	12/31/2025	▪Continue expanding the diabetes management program by identifying eligible members using the clinical risk stratification tool and the gaps in care dashboard ▪Continue to support members in condition management through education, community-based referrals, and coordination of care	• Increase the percentage of diabetic members with Blood Sugar Controlled (A1C<9) by 1.5%	Director of Health Plan Care Management CM Operations Manager CM Clinical Manager	QMC	Annually			x									

PH	Quality and Compliance Monitoring Activities	**Annual Population Assessment**	Popualtion Health annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner.	March QMC	**Assessment must consider and include the following:** **• Relevant characteristics of specific populations** **• DHMP's total covered population, not just members identified for complex case management** **• Needs of individuals with disabilities and serious and persistent mental illnesses**	• Use multiple data sources, when available, including administrative claims and utilization management data to assess the characteristics and needs of its member population and subpopulations • Reviews and updates its complex case management resources to address member needs, if necessary	**Pop Health Manager**	**MMC** **QMC**	**Annually**			x				x					
CM	Quality and Compliance Monitoring Activities	**Complex Case Management: Measuring Program Effectiveness**	Complex Case Management annually measures the effectiveness of its complex case management program using three measures.	12/31/2025	For each measure, Complex Case Management: •Identifies a relevant process or outcome •Uses valid methods that provide quantitative results •Sets a performance goal •Clearly identifies measure specifications •Collects data and analyzes results •Identifies opportunities for improvement, if applicable	Member Satisfaction: Member Satisfaction will indicate 80% satisfaction with the complex case management program.	**Director of Health Plan Care Management** **CM Operations Manager** **CM Clinical Manager**	**QMC**	**Annually**			x									
QI	Quality and Compliance Monitoring Activities	**Adoption and Distribution of Clinical Practice and Preventive Health Guidelines**	DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members and providers for the provision of non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties.	11/1/2025	• The QMC will review clinical care guidelines every 24 months, or per regulatory/contractual requirements. • This review may be more frequent if national guidelines change before the review date. • There must be evidence that they were revised based on adopting guidelines from a recognized source(s) or by using appropriate practitioner input.	Adoption and dissemination by: • Following regulatory/contractual requirements, DHMP will reach out to DHHA for current clinical/preventive care guidelines. • The DHMP medical director will consult with participating practitioners, and quality improvement (QI) staff will collect documentation related to a guideline. • Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. • Distribution to current practitioners and members may include targeted mailings, newsletters, DHMP's website, and/or the intranet.	**QI Manager** **Medical Director** **QI Project Managers**	**QMC**	**Annually**											x	
Marketing	Quality and Compliance Monitoring Activities	**Practitioner and Provider Communication Requirements**	The Marketing Department provides timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.	12/31/2025	**Practitioners and Providers are provided the following information, including but not limited to:** **• Member rights and responsibilities statement** **• The process for the practitioner to refer members to case management** **• Program information** **• Clinical practice and preventive health guidelines (to appropriate practitioners)** **• How to obtain UM criteria** **• How to access staff** **• An affirmative statement about incentives** **• Information about the quality program goals and process outcomes related to member care and service** **• Pharmaceutical management procedure, restriction and preference information, including formulary** **• Annual Provider Survey** **• Early Periodic Screening Diagnosis and Treatment (EPSDT)** **• HEDIS, CAHPS and Medicare Stars Ratings**	• Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter • Must provide evidence of annual communication to all network practitioners and providers Reports: NMC Reports QMC via NMC minutes annually	**Provider Relations Mgr**	**Network Management Committee** **QMC**	**Annually**	x											
QI	Quality Improvement Program Structure	**2025 QI Program Description**	The QI Program Description will be annually reviewed and updated according to NCQA standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC).	3/11/2025	**Annually** **Program must include:** • Program Structure • How patient safety is addressed • How designated physician is involved • How BH practitioner is involved • Oversight of QI functions by QMC • Annual work plan • Objectives for serving a culturally and linguistically diverse membership • Objectives for serving members with complex health needs, including behavioral health	• All requirements must be met • Reviewed and updated annually • Submitted for review to the QMC and BOD	**QI Manager** **QI Director (Sr. Director of Health Outcomes and Pharmacy)**	**QMC** **Board Of Directors**	**Annually**			x									
QI	Quality Improvement Program Structure	**2025 Annual QI Work Plan**	The QI Work Plan schedule is developed after review of previous year's QI Work Plan and Evaluation. The revised Work Plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measurable and analyzed annually during the Program Evaluation.	3/11/2025	**Work Plan must address:** • Performance Improvement Projects • Collection and Submission of Performance Measurement Data • Member Experience of Care • Under and Over Utilization of Services • Quality and Appropriateness of Care Furnished to Members • Quality of Care Concerns • External Quality Review • Advisory Committees and Learning Collaboratives • Quality and Compliance Monitoring Activities	• All nine requirements must be met • Yearly objectives must be measurable • Submitted to and reviewed by the QMC and BOD	**QI Manager** **QI Director (Sr. Director of Health Outcomes and Pharmacy)**	**QMC** **Board Of Directors**	**Annually**			x									
QI	Quality Improvement Program Structure	**2024 QI Program Evaluation Report**	The Program Evaluation report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI Work Plan.	3/11/2025	**Evaluation includes:** • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices	For all goals not met: • QI conducts a qualitative analysis to identify the underlying causes and recommend opportunities to improve. • Analysis must include organizational staff with direct experience of processes that have presented barriers to improvement. Evaluation Summary must include and address: • Analysis and overall effectiveness • Completed and ongoing activities • Trending of QI measures/results	**QI Manager** **QI Director (Sr. Director of Health Outcomes and Pharmacy)**	**QMC** **Board Of Directors**	**Annually**			x									

A&G	Quality Improvement Program Structure	G & A Dept (Part of QI Program Eval)	**The Program Evaluation report uses valid methodology, the organization annually analyzes nonbehavioral and behavioral health complaints and appeals for each of the five required categories.** **1. Access to care** **2. Customer Service/Member Satisfaction** **3. Billing/Financial** **4. Care Coordination** **5. Quality of Care- Grievances**	3/11/2025	**Evaluations is inlcuded in the QI Program Eval. The G&A Eval includes:** **•Member complaint and appeal data are correctly classified, processed and completed within regulatory timeframes. * Staff are able to investigate and close cases within KPI goals.**	98% of all submissions to be processed within timeframes. KPI goal is 50% of cases closed within 7-14 days (grievances)	**G & A Manager**	QMC Board of Directors	**Annually**			x									
Med Director, UM, A&G	Quality of Care Concerns	**Quality of Care Concerns (QOCC): Medicare, Exchange**	DHMP Medical Director and RN appropriately investigate potential QOCC's.	**Timeframe requirements:** •Acknowledgment letter: 5 business days. •Expedited Response: 72 hrs. •Standard Response: 30 business days. •Extension letter: 15 business days.	•100% Timeframe Compliance for processing cases within regulatory turn around and reporting time frames. • Report all cases to Credentialing Committee (and Quality Management Committee ad-hoc if warranted based on trends/seriousness) noting substantiated cases which either need track/trending or referral to recredentialing • Allow facility/providers to submit responses on substantiated cases to allow for internal reviews and quality improvement.	Ensure patient safety regulatory requirements are met as it relates to quality of clinical care concerns.	**G&A Mgr.** **QOC Nurse/Designee** **Medical Director**	**QMC**	**Every other Month**	x		x		x		x		x		x	
CM	Under and Over Utilization of Services	**Plan All Cause Readmissions (PCR)**	To develop interventions to reduce the number of 30-day plan all cause readmissions in 2023	12/31/2025	**Procedure**: The Transitions of Care team is responsible for following exchange members who are admitted to an inpatient setting outside of DHHA, and Medicare members who are admitted to DHHA as well as external facilities. The Transitions of Care team offers support to discharge planners to ensure a safe discharge plan is in place for the member and then follows the member for 30 days upon program enrollment (outreach for enrollment occurs after discharge to a home setting). The DHMP Population Health team will be working with DHHA to evaluate their Transitions of Care interventions for DHMP members admitted at a DHHA facility. **Reports**: Validated Rates to QMC Annually	Goals: Reduce Plan All Cause Readmission Rates for members (Goal <10%)	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**												
CM	Under and Over Utilization of Services	**Reduce costs for members engaged in the High Utilizer Medication Management Program**	The DHMP pharmacy team monitors members pharmacy utilization and will identify member that are on high-cost drugs and will refer them to the care coordination team for review and evaluation for case management services. The care coordination team will outreach to the member to discuss their specific condition and associated pharmacy needs. The care coordinator will attempt to get the member connected to a primary care provider if the member does not already have one.	12/31/2025	•Continue to identify members who may be eligible for the High Utilizer Medication Management Program through internal and external referrals	Reduce annual costs for members in the high utilizer medication program by $500,000 annually	**Director of Health Plan Care Management** **CM Operations Manager** **CM Clinical Manager** **Director of Pharmacy**	**QMC**	**Annually**												
PH, HEDIS	Collection and Submission of Performance Measurement Data	**Bone Density Screening (OMW)**	To improve HEDIS rates for the measure, Osteoporosis Management in Women who had a Fracture.	Create monthly list of women 67-85 years of age who had a fracture in the last 3 months and who have not had either a bone mineral density test or a prescription for a drug to treat for osteoporosis since the fracture. Provide to ACS Central Clinical Support pharmacy team for follow up monthly. Schedule quarterly meetings to discuss intervention progress and barriers. **Reports:** Validated Rates to QMC Annually QMC Annually	**"Medicare Current HEDIS MY2021: NA (less than 30 in universe)** **Goal Medicare MY 2022 HEDIS Rate: 64% (4star cut point)"**		**PH Manger** **PH Project Managers**	**QMC**	**Annually**				x								
PH, HEDIS	Collection and Submission of Performance Measurement Data	**Improving Diabetic Retinal Exams**	To improve HEDIS rates for the Eye Exam for Diabetics (EED) measure Quality team will target members for outreach who meet the following criteria: (1) the member is 18-75 years of age, (2) the member has been diagnosed with diabetes (type 1 and type 2), (3) the member has not had a retinal exam performed is the last year.	12/31/2025	**Create monthly list of members with a diagnosis of diabetes, 18-75 years of age that have not had a dilated retinal exam in the last year. Provide to ACS Eye Clinic Navigators and Primary Care navigators to outreach and schedule the exam.** **Support ACS Primary Care Clinics in the increased usage of Eye Cameras at DH clinics Reports: Validated Rates to QMC Annually**	Medicare Current HEDIS MY2023: 73% Goal Medicare 2025 HEDIS Rate: 78% (4 stars)	**PH QI Project Managers**	**QMC**	**Annually**				x								
PH, HEDIS, QI	Collection and Submission of Performance Measurement Data	**Improving performance in Initiation and Engagement in Treatment for SUD - Initiation (IET) HEDIS measure**	Improve HEDIS rates for IET measure for the Exchange population to support NCQA QI3.	12/31/2025	Collaborate with Center for Addiction Medicine to receive biweekly data feeds of Exchange members with newly diagnosed SUD. Review clinical treatment recommendations and outreach to members to support beginning a treatment modality.	Exchange Current HEDIS MY2023: 45.45% Goal Exchange 2025 HEDIS Rate: 50th percentile	**PH /QI Project Managers**	**QMC**	**Annually**				x		x		x		x		

PH, HEDIS	Collection and Submission of Performance Measurement Data	Improving Well-Child Visits: School-Based Health Centers Targeted Lists (perhaps consolidate w/another row)	QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. **Objective:** Increase the % of Commercial members with a well-child visit by providing targeted lists to SBHCs HCPs	**Procedure:** •SBHC creates list of enrolled members by LOB in DHHA EPIC system •DHMP pull list from EPIC and determines who needs visit and sends list back to clinics so HCPs can complete well visit in SBHC.	**Goal:** Assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit. >50% of eligible population receive well visit through SBHC		PH/QI Project Managers	QMC	Annually								x				
QI	Quality and Appropriateness of Care Furnished to Members	Encourage its providers to participate in CMS and HHS quality improvement initiatives	Annually, at minimum, review CMS/HHS QI initatives that health plans are required to encourage providers to participate in.	3/11/2025	Ensure QI team compliance with annual CMS readiness checklist provided by Product Line Manager. - Chronic Care Improvement Project (CCIP) - Quality Improvement Program (QIP) - Model of Care (MOC) for SNP Requirements (including but not limited to annual training for its providers on MOC) - Performance measurement (e.g. HEDIS, CAHPS, HOS) - Review to ensure adherence to CMS quality standards - Clinical Practice Guidelines and Care Transition Protocols	Ensure DHMP QI program and QAPI reporting alignment with CMS and HHS QI requirements.	QI Manager QI Project Manager NCQA Project Manager Product Line Manager	QMC	Annually				x								
QI, PH	Quality and Appropriateness of Care Furnished to Members	Medicare Chronic Care Improvement Program (CCIP)	Phase II (Monitoring & Adjusting): Goal of the Controlling Blood Pressure Management program is to increase the percentage of MCR Select members with a diagnosis of hypertension whose BP is in control based on the CBP HEDIS metric. We will move to Phase III (Evaluation & Reporting) in 2026.	12/31/2025	3-year CMS-required CCIP project that focuses on promoting effective management of chronic disease, slowing disease progression, reducing complications and utilization. In addition, the program should improve care and health outcomes for enrollees, address potential health disparities and produce best practices. For the three-year cycle that started 2024, DHMP chose to focus on control of high blood pressure in those MCR members who have a diagnosis of hypertension. The DHMP Quality Improvement team will work closely with DHMP Care Management and DHHA Ambulatory Care Services to implement a comprehensive chronic disease care management program in order to provide members with poorly controlled blood pressure the support and care they need to more adequately manage their condition.	Goal Exchange MY2025 HEDIS Rate: 75th percentile	PH Manager PH/QI Project Managers QI Manager	QMC	Annually					x							
CM	Quality and Compliance Monitoring Activities	Complex Case Management: Population Assessment	Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner.	3/1/2025	**Assessment must consider and include the following:** •Relevant characteristics of specific populations •DHMP's total covered population, not just members identified for complex case management •Needs of individuals with disabilities and serious and persistent mental illnesses	•Use multiple data sources, when available, including administrative claims and utilization management data to assess the characteristics and needs of its member population and subpopulations •Reviews and updates its complex case management processes to address member needs, if necessary	Director of Health Plan Care Management; CM Operations Manager	QMC	Annually				x								
PH	Collection and Submission of Performance Measurement Data	Colorectal Cancer Screening: FIT kit mailing initiative	To develop interventions to increase the number of FIT kits completed by DHMP MCR members in 2025.	12/31/2025	**Procedure: DHMP will collaborate with DHHA ACS and vendor, LGC to conduct mailing of FIT kits to MCR members who had not completed colorectal cancer screening in the measurement year** **Reports: Validated Rates to QMC Annually QMC Annually**	Colorectal Cancer Screening (COL) Commercial Current HEDIS MY2022: 56.2% Commercial HEDIS MY2024 Goal: 59.2% Exchange Current HEDIS MY2022: 48.7% Exchange HEDIS MY2024 Goal: 51.7% Medicare Current HEDIS MY2022: 74.7% Medicare HEDIS MY2024 Goal: 77% (4-Star cut point)[l]	PH Project Manager	QMC	Annually								x			
PH	Quality and Appropriateness of Care Furnished to Members	Population Health Management (PHM) Strategy: Program Monitoring	The Population Health Management Team has a population health strategy for meeting the care needs of its member population.	March 2025 QMC	**The strategy describes goals and populations targeted for each of the four areas of focus, Keeping members healthy, Managing members with emerging risk, Patient safety or outcomes across settings, and Managing multiple chronic illnesses, the programs and services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about PHM programs.**	2024 PHM Goals: Establish programming for each of the four population health target areas. •Keeping members healthy •Managing members with emerging risk •Patient safety or outcomes across settings •Managing Multiple Chronic Illnesses The Population Health team has developed the 2025 Population Health Management Strategy for the MCR,and Exchange lines of business. The Strategy outlines the strategic PH Plan, PH Goal and specific programs that will support these members.	PH Manager and PH/QI Project Managers	QMC MMC	Annually						x					
CM	Collection and Submission of Performance Measurement Data	Care for Older Adults Pain Assessment (COA)	To develop interventions to improve the rate of members who have had a pain assessment	12/31/2025	Procedure: The CM team will conduct outreach to members identified by the Quality Improvement team as needing a pain assessment completed. The CM team will complete a pain assessment with members and provide follow up with the member's care team as appropriate. Reports: Validated Rates to QMC Annually	• Increase the percentage of members with a pain assessment completed by 1.5%	Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement	QMC	Annually												
UM	Quality and Appropriateness of Care Furnished to Members	2024 Utilization Management Program Evaluation	The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence.	3/11/2025	**Presentation to QMC must include:** •Committee discussion and input on program summary •Actions, if applicable •Committee approval UM Program and evaluation of prior year performance Evaluation includes: •Completed and ongoing activities •Quantitative and Qualitative Analysis •Evaluation of effectiveness Reports: Annually QMC	A summary of these results is presented to the MMC & QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program.	Medical Director UM Director	QMC	Annually				x								

A&G	Collection and Submission of Performance Measurement Data	**Quality of Service Concerns (QSC)**	• The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns with a goal of I00% Timeframe compliance	**Timeframe requirements:** •Acknowledgment letter: 5 business days. •Standard Response: 30 calendar days. •Extension letter: 15 calendar days (Commercial, Exchange), 14 calendar days (Medicare). •Expedited: 72 hours Monitors Tracks: Monthly **Reports**: QMC Quarterly	Tracks G&A Types, timeliness, and documents trends, quarterly updates presented to QMC		**Manager of Appeals & Grievances** **Director of Provider Network** **Adhoc**	**QMC**	**Quarterly**	x			x		x				x		
UM	Quality and Appropriateness of Care Furnished to Members	**Monitoring Satisfaction with the Utilization Management and Data-Sharing**	DHMP continually assesses member and practitioner satisfaction with our Utilization Management and data sharing to identify areas in need of improvement.	9/1/2025	**Components of the process:** **•Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities** **•Taking action designed to improve member and practitioner satisfaction based on assessment of the data**	•Members: 90% of the surveyed members (CAHPS) who required an authorization for services will indicate being either "Somewhat or Very Satisfied" with the authorization process. Practitioners: 90% of the surveyed providers will indicate a high level of satisfaction with the UM program by answering each of the Provider UM Satisfaction questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied)." [Provider, Practitioner Experience Survey sent by PR annually]	**QI Manager** **Director of Member and Provider Experience (Survey and analysis, action plans)** **Manager of Marketing and Provider Relations (PR)** **Director of UM**	**QMC**	**Annually**			x									