COLORADO
Department of Health Care Policy & Financing

Quality Improvement Plan

Instructions and Narrative Report

RAE/MCO Name:
RAE/MCO Region #:
RAE/MCO Contact Name:
Date Submitted:
Contract Reference: 13.2.

Purpose: Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs) are required to develop and implement a Quality Improvement Plan to monitor and continually improve the quality of care received by its members. As part of that requirement, RAEs and MCOs must implement a Quality Improvement Plan.

Evaluation Period: The Quality Improvement Plan will be collected once in the initial year of the ACC Phase III contract and will outline the planned quality improvement activities for fiscal Year 2025-2026. Any subsequent updates to the quality improvement work will be documented in the Annual Quality Improvement Report.

Instructions: Please complete the Quality Improvement Plan Sections as outlined below.

Included in this report:

- Population Health Initiatives
- Clinical Measures of Quality Care
- Performance Improvement Projects
- Quality of Care Grievances

1. Please describe the RAE/MCO performance improvement projects.

In SFY 2024–2025, DHMP will have completed its required PIP focused on improving Social Determinants of Health (SDOH) screening rates among Medicaid and CHP+ members seen at Denver Health Ambulatory Care Services. Final PIP documentation, including the validated outcomes and intervention summaries, will be submitted to the State by October 2025. Both the Medicaid and CHP+ PIPs received a *High Confidence* rating across all validation elements by HSAG, demonstrating robust methodology and evidence of significant improvement.

For SFY 2025–2026, DHMP will complete the close-out of the SDOH-focused PIP and begin planning for the next PIP cycle. A new non-clinical PIP topic will be selected in July 2025 in alignment with current State guidance. Early SFY activities will include:

- Review of priority quality domains and available performance data

- Stakeholder engagement across DHMP and Denver Health teams
- Submission of the new PIP topic proposal to the State once selected
- Development of the PIP Aim Statement and baseline metrics

DHMP is committed to ensuring alignment of future PIP efforts with contract requirements and population health priorities and will incorporate any applicable feedback received during the previous validation cycle into the planning and implementation of the next PIP.

2. Please describe the RAE/MCO collection and submission of performance measurement data, including Member experience of care.

Healthcare Effectiveness Data and Information Set (HEDIS) MY2025 Annual Analysis: The Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized set of performance measures used to evaluate the quality and effectiveness of health care services. HEDIS data allows for the comparison of health plan performance against peer organizations, as well as national and regional benchmarks. Annual analysis and trending of this data support the identification of high-priority measures and reveal opportunities for ongoing quality improvement.

- HEDIS data will be collected from multiple sources, including electronic clinical data systems, administrative, hybrid methodologies and member surveys. These sources encompass medical chart reviews, pharmacy data, laboratory reports, care management system data and insurance claims related to hospitalizations, office visits and medical procedures.
- Prior to submission in June 2025, all HEDIS data will be validated by an NCQA-approved third-party auditing firm to ensure accuracy and compliance.
- Denver Health will successfully meet all Measurement Year (MY) 2025 HEDIS reporting requirements and submission timelines.
- Validated HEDIS results will be reported to the Quality Management Committee (QMC) to inform oversight and guide quality improvement efforts.

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. 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 50+ years old. PH Project Manager:

- Conducts monthly data pull
- Defines eligible participants
- Distributes member list for mailing

Improving Timeliness of Prenatal Care (PPC): DHMP PH Program Manager present current performance metric data of PPC Timeliness measures to the DHHA ACS Perinatal workgroups. The "DHMP PH/QI Program Managers provide metric education, guidance on appropriate coding to capture data effectively, and propose interventions to improve metric. Procedure: PH Collaborates with CM and IS to evaluate current performance and share data to inform CM interventions

- PH participates in the perinatal workgroup on a monthly basis. This workgroup is on hold as of January 2025 but anticipates restarting in July 2025.
- PH participates in QI committee activities for improvement of prenatal timeliness and Postpartum Care.

Improving Postpartum Care (PPC): DHMP PH Program Manager present current performance metric data of PPC measures to the DHHA ACS Perinatal workgroups. The "DHMP PH/QI Program Managers provide metric education ,guidance appropriate coding to capture metric and propose interventions to improve metric. PH Collaborates with CM and IS to evaluate current performance and share data to inform CM interventions.

- PH participates in the perinatal workgroup on a monthly basis. This workgroup is on hold as of January 2025 but anticipates restarting in July 2025.
- PH participates in QI committee activities for improvement of postpartum care timeliness.

Improving Child and Adolescent Well Care Visits: To improve the Medicaid and CHP+ rates for Child and Adolescent Well-Care Visits. The following interventions will be ongoing in 2024/25:

- Healthy Heroes Birthday Cards
- SBHC Targeted Lists (as staffing capacity allows)
- Overdue WCV Outreach Calls
- Reported: Validated Rates to QMC Annually

Improving Well-Child Visits: Healthy Heroes Birthday Cards: Children 2-19 years of age who still require an annual well child visit for the year will receive a birthday card informing them to come for their annual visit. Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care. Procedure:

- PH pulls list from BI portal monthly
- PH cleans data and separates per LOB
- PH forwards list to the printer to send out reminder cards

Improving Well-Child Visits: School-Based Health Centers Targeted Lists: Once a year, PH receives a list of all MCD and CHP+ members enrolled in the SBHC program.

- PH runs the list against active members and targets all members in need of a well-child visit.
- Increase the % of MCD and CHP+ members with a well-child visit by providing targeted lists to SBHCs HCPs.
- SBHC tracks enrollment and which members are in need of a visit via EPIC report—SBHC Care Coordinators outreach to DPS members who complete Annual Wellness visit at appropriate SBHC.
- DHMP tracks completed visits via claims (HEDIS monthly run).

Monitoring Pharmacy Benefit Information for Quality and Accuracy: The Pharmacy Department has a quality improvement process in place to assess the quality and accuracy of pharmacy benefit information provided to members telephonically and online. 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: MMC Yearly

Monitoring Member Services' Benefit Information for Quality and Accuracy: The Health Plan Services (HPS) Department has a quality assurance program (HPS QA) that determines any deficiencies in quality and service provided by Health Plan Representatives (HPR) and works to correct any identified deficiencies and support areas of improvement. This is a valuable tool in staff development and satisfaction and is also incorporated into the annual HPR evaluation process to ensure that it is meaningful to the team and its individual members both telephonically and online. 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: Daily/Monthly
- Reported: QMC/MMC Quarterly
- Share monthly at a minimum with HPS staff in group/individual meetings.

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. 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

Monitoring Satisfaction with Complex Case Management: The Care Management Member Experience survey provides DHMP with important insight into the member's experience with case management services and provides information on how DHMP can improve the member's experience with the Care Manager and the overall program. In addition, the analysis of complaint data in conjunction with the survey results helps DHMP get a direct read on problems of which we might not be aware. The complaint data helps us pinpoint specific issues and process failures that might not have been isolated or identified in the care management survey.

Cultural and Linguistic Appropriate Services (CLAS): DHMP ensures culturally and linguistically appropriate services to our membership by analyzing available REL data, ensuring important plan materials are available in prevalent languages, at appropriate literacy levels, and ongoing effort to reduce health disparities/improve health outcomes.

- Reports: QMC Annually
- Reinforce non-judgmental, person-centered language in member interactions and documentation, in alignment with the Center for Addiction Medicine's (CAM) Words Matter campaign.

3. Please describe the RAE/MCO's mechanisms to detect both underutilization and overutilization of services.

Reduce 30 day plan all cause readmissions and improve health outcomes for members following an inpatient stay: The DHMP TOC Program is an evidence-based program that focuses on helping reduce preventable readmissions by providing knowledge, confidence, and ability to self-manage health conditions. Transitions nurses support members and the inpatient care team during the inpatient stay and member discharge, and follow, educate, and support members for 30 days following their hospital discharge. DHMP TOC staff identifies and coordinates transitions of care for patients to reduce readmissions, improve quality of care and improve patient and family satisfaction.

The Care Management team also offers member support through the Wellframe Application, which provides access to self-management programs, including a Transitions of Care Program. This program is offered as an alternative to members who do not wish to participate in the full TOC program. Wellframe offers digital care management through an app for the end user, with bi-directional chat features to help members stay more connected with their care managers. Members have the option to participate in self-directed programs on the application, complete

well-being check ins and assessments, track medications, communicate and share biometric data with their CM, and exchange information and resources digitally. Wellframe provides alerts to the member's care manager when member needs are identified.

Planned Activities:

- Use the ADT feed in Square ML to identify admissions, discharges, and transfers
- Identify and prioritize members with risk factors:
    - Readmission Risk
    - Potentially Avoidable Admission
    - Care Costs >$25,000
    - 3+ Chronic Conditions
    - LOS >14 days
- Coordinate with Utilization Management to identify complex cases
- Onboard members onto the Wellframe Application to expand access to TOC services

Objective/Metrics: Increase member engagement in the TOC program

- Increase enrollment of TOC referred members to a minimum of 35 distinct members/month per Care Manager
- Ensure that at least 25% of enrolled members in the TOC program are invited and onboarded on the Wellframe Application

Timeline:

- January 1, 2025 – December 31, 2025
- Reports Annually at QMC

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 care 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.

Planned Activities: Continue to identify members who may be eligible for the High Utilizer Medication Management Program through internal and external referrals

Objective/Metrics: Reduce overall cost for members in the High Utilizer Medication Management Program

- Reduce Annual costs for members in the High Utilizer Medication Management Program by $2,000,0000 annually (across all lines of business)

Timeline:

- January 1, 2025 – December 31, 2025
- Reports Annually at QMC

4. Please describe the RAE/MCO's mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department.

Pharmaceutical Patient Safety Issues: The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacists or practitioners. This represents an opportunity to provide patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons.

- 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

UM Annual Eval: DHMP annually evaluates & updates the UM program, based on the performance of its program goals.

- Assessing data from staff daily workflow
- Assessing daily operations against key performance indicators
- Assessing results of annual IRR testing
- Updating Internal Criteria Policies to ensure best practice and benefits are being met
- Identifying opportunities for improvement and implementing interventions if applicable
- Measuring effectiveness of interventions, if applicable

Review of UM program: DHMP remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.

- COA is our delegate for BH care.

Criteria for UM decisions: DHMP makes UM decisions in a timely manner to minimize any disruption in the provision of healthcare. DHMP monitors and submits a report for timeliness of all requests. DHMP follows mental parity requirements. DHMP uses nationally recognized evidence based criteria guidelines to make utilization decisions, and specifies procedures for appropriately applying the criteria.

- UM decision-making criteria are objective and based on medical evidence.
    - UM uses MCG Guidelines for review.
- Written policies for applying the critera based on individual needs.
- Involves appropriate practitioners in developing, adopting and reviewing criteria.

- Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.
- Annually evaluates the clinical reviewers use of criteria to ensure fair application of criteria for all members.

Promote and improve health outcomes for members with complex needs: DHMP's Complex Care Program addresses the complex medical, behavioral, and/or psychosocial needs of members by providing personalized care management services and goal setting. The program is designed to help members with complex conditions and social situations to obtain access to necessary care and services in a coordinated and cost-effective manner. Members are identified for outreach using the clinical risk stratification dashboard. Outreach lists are generated routinely for the MCD team. Members are identified as complex needs if they meet the following criteria:

- Adolescent members with care costs >$25,000
- Adult members with 3+ HCPF-defined "winnable" conditions and care costs >$25,000

DHMP is in the process of re-defining its complex needs and rising risk population in coordination with the state, so these definitions may change during SFY 2025-2026 in accordance with the new tiering system.

Planned Activities: DHMP Care Management will increase outreach and ECC engagement efforts for members with complex needs, with special focus paid to the following populations:

- Members in foster care
- Members with disabilities
- Members with Special Health Care Needs

DHMP is in the process of re-defining its complex needs and rising risk population in coordination with the state, focus populations may change during SFY 2025-2026 in accordance with the new tiering system.

Objective/Metrics: Increase engagement in CM services and programs for members with Complex Care Needs

- Increase the average percent of complex care members enrolled in extended care coordination by 2 percentage points from SFY 2024-2025 (41.56% Baseline)
- Increase the average percent of complex care members outreached for CM services by 2 percentage points from SFY 2024-2025 (31.53% Baseline)

Timeline:

- July 1, 2025 – June 30, 2026
- Reports Annually at QMC

Improve and promote health outcomes for members with high-risk pregnancies: The DHMP Maternal Care Management Program provides care management services by social workers, registered nurses, and a registered dietitian for high-risk women during pregnancy and for up to a year after delivery. The goal of this program is to ensure healthy pregnancies and healthy babies. The CM staff provide moms and kiddos help in managing access to care, coordination of care, developing individualized plans of care, assist with medication management, help arrange transportation to medical appointments, referrals to other programs like childbirth and breastfeeding education classes, family planning and to the WIC program. DHMP works in partnership with the providers and services offered at Denver Health.

The Care Management team also offers member support through the Wellframe Application, which provides access to condition-specific self-management programs, including maternal care programs. Members may opt into both the self-management program or the full program offered by the plan, or they can participate in both. Wellframe offers digital care management through an app for the end user, with bi-directional chat features to help members stay more connected with their care managers. Members have the option to participate in self-directed programs on the application, complete well-being check ins and assessments, track medications, communicate and share biometric data with their CM, and exchange information and resources digitally. Wellframe provides alerts to the member's care manager when member needs are identified.

Planned Activities:

- Support members with engagement in prenatal and postpartum care through coordination with DHHA's maternal care clinic and high-risk maternal care team
- Engage prenatal and postpartum members in the Wellframe Application

Objective/Metrics: Increase rates of prenatal and postpartum engagement for members

- Ensure that at least 81.8% of pregnant members receive a timely prenatal care visit
- Ensure that at least 77.5% of postpartum members receive postpartum care
- Enroll at least 25% of members with the maternity indicator in the Wellframe Application

Timeline:

- January 1, 2025 – December 31, 2025
- Reports Annually at QMC

Improve and promote health outcomes for members with Special Health Care Needs: DHMP's Special Health Care Needs Program addresses the complex medical, behavioral and/or psychosocial needs of members by providing personalized care management services and goal setting for members meeting SHCN criteria. Services are focused on meeting the complex needs of members with SHCN, including benefit coordination and access to services to include

well child checks, LTSS, and PDN services. Members are identified for outreach through a variety of sources, including MCD reporting, state reporting, provider referrals, UM referrals, and through use of the risk stratification tool.

Planned Activities:

- Targeted outreach to members with special health care needs for short and long-term care management services
- Continue to grow the SHCN program
- Provide additional support to members/caregivers through the Wellframe Application
- Explore expansion of the pediatric complex care definition to include members with special health care needs

Objective/Metrics: Increase member engagement for members with Special Health Care Needs

- Increase the average percent of members with Special Health Care Needs enrolled in at least one CM program by 2 percentage points from the CY 2024 average of 11.02%

Timeline:

- July 1, 2025 – June 30, 2026
- Reports Annually at QMC

Improve and promote health outcomes for MCD members who are in foster care: DHMP's CM team has a Foster Care Program to support the unique needs of members in this program, who are provided care coordination assistance in a direct partnership with the Connections for Kids Clinic (CFKC) at Denver Health's Eastside Clinic, a medical home for children and youth in kinship and foster care. Care Managers assists members and their families with obtaining routine and timely physical and dental exams as well as comprehensive care. DHMP in coordination with the CFKC performs visits/assessments for foster care children. During the first 3 months of care, 3 visits are completed with the member and assessments/evaluations are completed at each of these visits to support member needs. This partnership ensures that foster care children residing within Denver County have access to all DHMP resources and support that is available. This clinic designation allows providers to provide a high level of care coordination and assistance to the child/family.

Planned Activities:

- Use risk stratification data to identify members in foster care and generate outreach lists

Objective/Metrics: Increase member engagement for members in Foster Care

- Increase the average percent of members with the foster care indicator outreached for CM services by 2 percentage points from the CY 2024 baseline of 3.17%

Timeline:

- July 1, 2025 – June 30, 2026
- Reports Annually at QMC

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.

Planned Activities:

- 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

Objective/Metrics: Increase the percent of diabetic members with Blood Sugar Controlled (A1c <9.0%)

- Increase the percent of Medicaid and DSNP members who have an A1c reading in control by 2 percentage points from the CY 2024 rate of 57.07%
- Increase the average percent of members with diabetes who are engaged in a care management program by 2 percentage points from the CY 2024 rate of 31.68%

Timeline:

- January 1, 2025 – December 31, 2025 (A1c Control)
- July 1, 2025 – June 30, 2026 (DM Program Engagement)
- Reports Annually at QMC

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. 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.

Planned Activities: DHMP Medical 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)

Objective/Metrics: 2025 SNP MOC Overall Goals:

- Promote and improve coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP, and ICT:
    - Improving or maintaining member physical health – 76.00%
    - Members Who Completed HRAT – Initial – 75.00%
    - Members Who Completed HRAT – Annual – 75.00%
- Promote and improve health outcomes for D-SNP members with chronic conditions
    - Diabetes – Blood Sugar Controlled (<9.0%) – 80.00%
    - Controlling High Blood Pressure – 74.00%
- Promote appropriate utilization of services
    - Rate of Emergency Department Visits/1000 members – <110.70
    - Rate of Inpatient Admissions/1000 members – <32.16
    - Plan All Cause Readmissions – <10.00%

Timeline:

- January 1, 2025 – December 31, 2025
- Reports Annually at QMC

Health Equity Strategic Plan: Develop a health equity strategic plan to address health inequities experienced by DHMP MCD and CHP+ members. Submit Health Equity Plan to include baseline data, strategy, goals, timelines, resources, partnerships and results of efforts to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

5. Please describe the RAE/MCO's process for investigating quality of care grievances.

Quality of Care – Grievances: All member submitted grievances are classified as QOC-G's in alignment with the new HCPF process starting 7/1/2025. DHMP has been part of the pilot program to test the new reporting template to HCPF since March 2025. All grievances are tracked, monitored and reported to HCPF by the Appeals & Grievances (A&G) Department by the 10th of the following month. The Quality RN Delegate is notified of all grievance cases and reviews for risk level and potential serious harm to the members. Cases are investigated and

facility/provider input is obtained as necessary. The DHMP Medical Director reviews the concerns and classifies the cases as substantiated, unsubstantiated, or inconclusive. If a member reported concern is of an egregious nature, the case will be escalated to a QOC-C level. Reporting to external agencies is completed if needed. Cases are presented to the Credentialing Committee quarterly for possible corrective action if needed.

Timeframe requirements:

- Acknowledgment letter: 2 business days.
- Standard Response: 15 business days.
- Extension letter: 14 business days.

Quality of Care - Concerns: Any provider or facility submitted concerns as well as any serious potential harm/injury cases are automatically classified as QOC-C's. These cases are included on the new reporting template to HCPF and are part of the pilot program. Full implementation begins 7/1/2025. These concerns are referred directly to the Quality RN Delegate for initial investigation and presentation to the Medical Director. Input from the facility/provider is requested as appropriate. The DHMP Medical Director reviews the concerns and classifies the cases as substantiated, unsubstantiated, or inconclusive. Reporting to external agencies is completed if needed. Cases are presented to the Credentialing Committee quarterly for possible corrective action if needed.

Timeframe requirements:

- Acknowledgment letter: 2 business days.
- Standard Response: 15 calendar days.
- Extension letter: 14 calendar days.

6. Please describe the RAE/MCO's process for participating in External Quality Review. Please include the plan for reviewing and incorporating feedback from EQRO Activities.

Patient Safety Initiatives: Complete the annual State requirement for both Medicaid and CHP+ for serious reportable events occurrences.

- Compile data on serious reportable events for members.
- Investigate and perform root cause analysis on all events and present data to Medical Director.
- All events are decisioned as actionable (track and trend or credentialing review) or non-actionable.
- Results are presented to QMC annually.
- All state templates are submitted timely with full analysis.

HSAG Corrective Action Plan Standard V – Member Information Requirement 14: DHMP is working with HealthTrio as our front-end provider directory platform and Gaines as our

provider data management solution (PDMW). These vendors will ensure accurate and compliant provider data is integrated into DHMP's provider directory, addressing the required elements:

- Direct provider website URLs
- Cultural competency training status for providers
- Disability accommodations information

Final compliance evidence will include:

- Screenshots of the updated provider directory with new fields displayed.
- Demonstration of how members access provider URLs, cultural competency training status, and disability accommodations information.
- Verification of system compliance with required accessibility standards.

7. Please describe the RAE/MCO's use of advisory committees and learning collaboratives. This should include both internal and external meetings.

Quality Management Committee (QMC): Committee demonstrates quality oversight activities, 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
- 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

Medical Management Committee (MMC): DHMP's Medical Management Committee (MMC) acts as a working sub-committee of 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.

Network Management Committee (NMC): 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. The scope of the NMC responsibility includes: (1) Network development and procurement; (2) Provider contract management, including oversight; Maintaining Provider Directory and Provider Manual; and (3) Periodic assessment of network adequacy; focusing on both access and availability.

Member Experience Committee (MEC): Acts as a committee the discusses and implements strategies 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 including surveys after in person events, and call center contacts.
- Maintain a schedule of in person events that give members the opportunity to discuss issues both general and personal with health plan staff, and learn about different aspects, benefits, or processes about the health plan.
- Improve member experience between the member and plan by reviewing and implementing changes from the results of surveys, in person events, and feedback from internal teams.
- Enhance member usability and experience of plan benefits and tools
- Use MEC Smartsheet to review all member experience interventions, discussing the effectiveness of efforts.

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. Workgroups QI/PH participates in includes:

- Cancer Screening
- Health Related Social Needs (HRSN) Screening
- Pediatric QI
- Perinatal
- Asthma
- Immunizations
- Diabetes and Cardiovascular Disease

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 Medicaid and CHP+ plans comply 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. Committee functions include:

- Review and approve the Credentialing Charter, Credentialing Policies and Procedures and Credentialing Plan
- Review Practitioner applications, discuss qualifications, and approve or deny the application based on DHMP established criteria

- DHMP Medical Director reviews all clean files and makes a determination consistent with DHMP Credentialing policies and procedures.
- 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.
- Responsible for review and oversight of quality of care concerns and first level of review for potential disciplinary action consistent with DHMP policies and procedures.
- Responsible for review and approval of any internal UM criteria for medical necessity review.
- Responsible for review and approval of UM program description and annual evaluation.

MLR Metric Workgroup: To improve performance and meet state targets on Medical Loss Ratio (MLR) metrics. Create programs and interventions to close the performance gap between DHMP's current Medicaid performance and the HEDIS 90th percentile nationally by ten (10) percent during the measurement year.