2007-2008 External Quality Review Technical Report

for

Colorado Medicaid Managed Care

October 2008

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

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CONTENTS

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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' health plans. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the health plans. To meet this requirement, the State of Colorado Department of Health Care Policy & Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare a report regarding the external quality review (EQR) activities performed on the State's contracted health plans.

Scope of EQR Activities

This EQR report provides a description of the three federally mandated BBA activities and two optional activities.

As set forth in 42 CFR 438.352, these mandatory activities included:

- **Compliance monitoring evaluations.** These evaluations, conducted and reported on by the Department, were designed to determine the health plans' compliance with their contract and with State and federal regulations. The Department determined compliance through review of various compliance monitoring standards and through review of individual records to evaluate implementation of the standards.
- **Validation of performance measures.** HSAG validated each of the performance measures identified by the Department to evaluate the accuracy of the performance measures reported by or on behalf of a health plan. The validation also determined the extent to which Medicaid-specific performance measures calculated by a health plan followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** For each health plan, HSAG reviewed two PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services to be achieved and giving confidence in the reported improvements.

The optional activities included:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.** Each health plan was responsible for conducting a survey of its members and forwarding the results to HSAG for inclusion in this report. HSAG conducted the survey for the Primary Care Physician Program (PCPP) on behalf of the Department.
- **Focused studies.** HSAG conducted a hybrid study (coordination of care) and an administrative study (adolescent well care). Each health plan was responsible for collecting relevant data and submitting the data to HSAG for analysis. The Department provided information for the PCPP population.

For all available data in fiscal year (FY) 2006–2007 and FY 2007–2008, results are presented and assessed for the following:

- Denver Health Medicaid Choice (DHMC), a managed care organization (MCO)
- Rocky Mountain Health Plans (RMHP), a prepaid inpatient health plan (PIHP)
- Primary Care Physician Program (PCPP), a primary care case management program

Table 1-1 presents a synopsis of data available for this report. Designations of "NA" indicate that the data was not applicable to the health plans.

Table 1-1—Available Data for the FY 2007–2008 Colorado EQR Technical Report for the Health Plans

Data	DHMC	RMHP	PCPP
2007 Compliance Monitoring Evaluations	X	X	NA
2008 Compliance Monitoring Evaluations	X	X	NA
2007 Validation of Performance Measures	X	X	X
2008 Validation of Performance Measures	X	X	X
2007 Validation of PIPs	X	X	NA
2008 Validation of PIPs	X	X	NA
2006 Focused Studies	X	X	X
2008 Focused Studies	X	X	X
2007 Child CAHPS	X	X	X
2008 Child CAHPS	NA	NA	X
2007 Adult CAHPS	X	X	X
2008 Adult CAHPS	X	X	X

Overall Conclusions and Recommendations

To draw conclusions and make recommendations about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the components reviewed for each activity (standards, performance measures, PIPs, CAHPS, and focused studies) to one or more of these three domains as described in Appendices A–E of this report.

The following is a high-level statewide summary of the conclusions drawn from the findings of the activities regarding the health plans' strengths and HSAG recommendations with respect to quality, timeliness, and access. Section 3—Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access—provides detailed findings, strengths, and recommendations specific to each health plan.

Quality

All compliance monitoring standards were assigned to the quality domain: grievance and appeal, quality assurance program, credentialing and recredentialing of providers, and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The overall statewide average across the standards was 98 percent. A total of 147 out of 151 applicable provisions were scored as *Met*, 3 were scored as *Partially Met*, and one provision was scored *Not Met*. Both health plans scored 100 percent compliant for the EPSDT Program provisions. The lowest overall score was for Grievance and Appeal, which was 94 percent.

For performance measures, results in the quality domain demonstrated mixed performance from last year. Although a majority of the rates for measures with previous measurement results increased, HEDIS specification changes precluded any assessment of performance improvement for these measures. Nonetheless, two of the three comparable measures with applicable year-to-year comparisons showed improvement, one of which (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*) increased 8.63 percentage points. On the other hand, the rate for *Adolescent Well-Care Visits* decreased by 4.8 percentage points. In addition, when comparing the current statewide quality measures with the 2007 HEDIS Medicaid rates, three measures (*Well-Child Visits 3-6 Years of Life*, *Adolescent Well-Care Visits*, and *Annual Monitoring for Patients on Persistent Medications*) ranked below the 25th percentile, suggesting some opportunities for future improvement.

The EQRO activities related to PIPs were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. The PIP validation results were related to the domain of quality. Overall, the health plans demonstrated strength in using the CMS protocols in conducting PIPs. DHMC and RMHP achieved improvement or sustained improvement in some of the study indicators. DHMC's and RMHP's PIPs received a validation status of *Met*, with HSAG having confidence in the reported results. HSAG identified opportunities for improvement for each PIP and provided recommendations to the health plans on how to strengthen the current PIP structures and achieve improvement across all study indicators.

All of the measures within the CAHPS survey addressed quality. For the adult Medicaid population, four of the comparable measures' rates increased: *Shared Decision Making*, *Rating of Specialist*

Seen Most Often, *Rating of All Health Care*, and *Rating of Health Plan*. However, none of those increases was substantial.

The adult Medicaid survey results showed decreases for four of the measures. However, none of these decreases was substantial (i.e., none of the rates decreased more than 5 percentage points). Nonetheless, the State should continue to direct quality improvement activities toward those measures that had a decline in performance: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*.

Specific health plan recommendations are made within the findings section for each activity. In the domain of quality, HSAG's recommendations for the Department include:

- Collaborating with the health plans to find a method to track out-of-network EPSDT services such as dental, hearing, and vision examinations to ensure they are provided according to the established EPSDT periodicity schedule.
- Implementing quality strategies to improve the rate for *Annual Monitoring for Patients on Persistent Medications*. Potential strategies may include improving communication with members by sending annual reminders for physiologic or therapeutic monitoring tests with information about the importance of annual monitoring and the risk associated with noncompliance.

Timeliness

For performance measures, results in the timeliness domain demonstrated mixed performance from last year. Four of the seven comparable measures were not applicable for an assessment of performance due to HEDIS 2008 specification changes. Nonetheless, performance improved on *Well-Child Visits in the First 15 Months of Life* (*6+ Visits*) and *3-6 Years of Life* (with increases of 8.63 and 0.75 percentage points, respectively). On the other hand, the rate for *Adolescent Well-Care Visits* decreased by 4.8 percentage points. Comparing results of the current measurement year to the HEDIS Medicaid national rates, the State Medicaid program maintained a relatively high ranking for the two *Childhood Immunization Status* measures, with rates ranking above the 75th percentile. Measures related to *Well-Child* and *Well-Care* visits, on the other hand, ranked below the 50th percentile for 2007. These results suggested opportunities for improvement on the timeliness measures, especially for *Well-Child* and *Well-Care* visit measures.

In the domain of timeliness, HSAG recommends:

- Implementing quality strategies to improve the rate for *Adolescent Well-Care Visits*. The State may collaborate with health plans to develop posters and new Medicaid member welcome letters that stress the importance of well-care visits. The Department could remind health plans and providers about its Web site, where they can access the Department's EPSDT toolkit. The toolkit includes a sample reminder letter that can be mailed to parents and guardians, notifying them that their child is overdue for an exam. This letter reminds parents of the importance of well-care appointments and explains what can be expected during a well-care appointment.

- The Department could encourage health plans to conduct ongoing reviews of utilization for members younger than 21 years of age to identify those who are eligible for well-care visits. Quarterly reports that highlight adolescents in need of well-care visits could be generated for providers and used to promote visit reminders.

Access

For performance measures, statewide performance in the access domain demonstrated opportunities for improvement for the Medicaid program. Although rates for *Timeliness of Prenatal Care* and *Postpartum Care* increased from the previous measurement year, these measures had HEDIS specification changes that prevented a direct year-to-year rate comparison. Nonetheless, the higher rate reported in the current measurement year for *Postpartum Care* had improved the Medicaid program's relative ranking in the 25th–50th percentile last year to the 50th–75th percentile this year. The health plans also had the opportunity to improve *Adults' Access to Preventive/Ambulatory Health Services*; Colorado ranked below the Medicaid 2007 national 25th percentile on this measure.

The Coordination of Care focused study provided baseline information on utilization of medical services by members diagnosed with a serious mental illness (SMI). Colorado Medicaid behavioral health services are "carved out" and provided through behavioral health organizations (BHOs). The inherent structure of carve-outs coupled with special protections established in Colorado statute for individuals with an SMI contribute to barriers in coordinating care between the medical and behavioral health delivery systems. The Department has made increased coordination of care between behavioral health and physical health care providers a high priority and has initiated activities within both systems to explore ways to improve coordination.

The Department hosted a discussion between the Medical Quality Improvement Committee (MQuIC) and Behavioral Quality Improvement Committee in August 2007. The meeting resulted in a plan to immediately begin addressing coordination issues. The Department arranged for an educational presentation at the February 2008 MQuIC meeting, where representatives from BHOs provided information on referrals and provided directories of key contacts to health plans. A Department BHO contracts manager and the executive director of the Colorado Behavioral Healthcare Council also participated in this forum to explore care coordination solutions. The collaboration resulted in the decision to conduct a utilization study to identify where and how frequently members with an SMI access medical care. The study is a first step toward understanding this vulnerable population's use of services to pinpoint key areas in which to improve communication. Although no firm conclusions could be drawn from the baseline data, the Department has prioritized the issue of coordination of care between the behavioral health and physical health delivery systems and has concrete plans to pursue activities and interventions toward this end.

The rate for *Adolescent Well-Care Visits* increased from the FY 2005–2006 study but remained below the National Committee for Quality Assurance (NCQA) HEDIS 2007 national Medicaid 50th percentile. The percentage for *Adolescents With Services but no Physician Office Visit or Well-Care Visit* decreased 3.1 percentage points from FY 2005–2006 to FY 2007–2008. This change indicates that more adolescents were having well-care visits and physician office visits. The opportunity to

perform a well-care visit during a physician office visit increased 17.2 percentage points from FY 2005–2006. This finding suggests an opportunity to increase well-care visits.

In FY 2007–2008 a prenatal and postpartum intervention survey was conducted to identify specific reasons women did not receive timely prenatal or postpartum care. HSAG selected a random sample of 500 women who gave birth in July through September 2007, were clients of either the Colorado Medicaid fee-for-service (FFS) program or the Primary Care Physician Program (PCPP), and had not received timely prenatal care as defined by the HEDIS technical specifications for the *Timeliness of Prenatal Care* measure for participation in the survey.

A total of 52 (11.2 percent) completed surveys were returned. The lack of adequate sample size was a major limitation of the study. Without an adequate sample size, it may not be feasible to extrapolate the study's results to the entire population. The number of survey respondents (52) yielded a margin of error of +/- 14 percent.

The main findings from the survey showed that approximately 41 percent of the respondents did not receive timely prenatal care. Of the 41 percent who did not receive timely prenatal care, approximately 45 percent indicated they were not able to see a doctor or nurse as soon as they wanted, with some respondents stating their doctors were not close enough in proximity. However, of all women responding to the survey, 78 percent were able to see a doctor or nurse as soon as they wanted. When assessing adequate postpartum care, the predominant barrier to care was the lack of Medicaid coverage after pregnancy. Some respondents noted that customer service and member communication was poor, which may have also contributed to the timeliness of care.

Specific health plan recommendations are made within the findings section for each activity. In the domain of access, HSAG's recommendations for the Department include:

- Explore quality strategies tailored to specific age or gender groups to improve the rate for *Adult's Access to Preventive Care/Ambulatory Care*. The State may collect current practice information from health plans and providers within the State or from other states to identify any best or promising practices for improving this measure.
- To facilitate coordination of care between behavioral health and physical health providers, the Department could consider providing health plans with a list of their members diagnosed with an SMI. In addition, the Department could consider facilitating quarterly regional meetings between the health plans and behavioral health organizations.
- Based on the findings from the prenatal/postpartum survey, HSAG recommends that the Department conduct a larger, more comprehensive focused study to identify additional barriers to prenatal and postpartum care. This study should survey a statistically valid sample of members and should include a customer service section to evaluate formally the effectiveness of existing processes and identify areas for improvement.
- In addition to conducting a larger, more comprehensive prenatal/postpartum focused study, the Department may elect to consider some additional activities to enhance the delivery of timely prenatal and postpartum care:
  - Streamline the Medicaid enrollment process to expedite access to care.

- Communicate the Medicaid enrollment process in any relevant publications and/or communications (e.g., Web sites, provider newsletters). This will ensure that the most accurate contact information is provided to the public to eliminate any existing disparities.
- Evaluate the Medicaid eligibility policy to reduce or eliminate any existing barriers to postpartum care.
- Educate providers and women about how long eligibility continues after delivery to ensure that both providers and consumers are aware of how long women have coverage to obtain postpartum care.
- Expand prenatal/postpartum provider networks by recruiting more primary care physicians.
- Enhance provider directories by publishing up-to-date information. This will help make the process of identifying a provider easier for consumers. The provider directory should also include a list of doctors currently accepting new patients.

2. External Quality Review (EQR) Activities

This EQR report includes a description of five performance activities: compliance monitoring evaluations, validation of performance measures, validation of PIPs, focused studies, and CAHPS. HSAG validated the performance measures, validated the PIPs, conducted the focused studies, and summarized the CAHPS results.

Appendices A–E detail and describe how HSAG conducted each activity, addressing:

- Objectives for conducting the activity.
- Technical methods of data collection.
- A description of data obtained.
- Data aggregation and analysis.

Section 3 presents conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each health plan and statewide, across the health plans.

3. Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

Introduction

This section of the report addresses the findings from the assessment of each health plan's strengths and opportunities for improvement related to health care quality, timeliness, and access derived from analysis of the results of the five EQR activities. This section also includes HSAG's recommendations for improving the quality and timeliness of, and access to, health care services furnished by each health plan. A subpart of this section details for each health plan the findings from the five EQR activities conducted. This section also includes for each activity a summary of overall statewide performance related to the quality and timeliness of, and access to, care and services.

Compliance Monitoring Site Reviews

The Department was responsible for the activities that assessed health plan compliance with federal Medicaid managed care regulations. This report reflects results from the annual compliance site visits that took place in 2008. For each health plan, the Department completed a Site Audit Findings report, the monitoring tool developed by the Department that captured all review findings. The site review team focused on four contract provisions: grievance and appeal, quality assurance program, credentialing and recredentialing of providers, and the EPSDT program. These contract provisions were chosen based on Departmental priorities as well as the need to review all contract provisions within a three-year cycle. HSAG examined, compiled, and analyzed the review results as contained in the health plan site visit documentation submitted by the Department.

For the review of the four compliance areas, the Department assigned individual provisions reviewed for each standard a score of *Met*, *Partially Met (PM)*, *Not Met (NM)* , *or Not Applicable (NA)*. The Department then determined a summary score by calculating the percentage of applicable provisions found fully or partially met. Any element receiving a rating of *PM* or *NM* required corrective action by the health plan. The health plans were required to submit a corrective action plan to the Department for approval within 30 days of receiving the final report. The Department reviewed, approved, and will monitor the corrective actions until compliance is demonstrated.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the health plans from the findings of the compliance monitoring activity, HSAG assigned each of the standards to one or more of the three domains as depicted in Table A-1 in Appendix A.

Appendix A contains further details about the methodology used to conduct the EQR compliance monitoring site review activities.

Denver Health Medicaid Choice

Findings

Table 3-1 presents the number of provisions for each of the four standards, the number of provisions assigned each score (*Met*, *PM*, *NM*, or *NA*), and the overall compliance score for the current year (FY 2006–2007).

Table 3-1—Summary of Scores for the Standards for FY 2007–2008 *for* DHMC

Description of Standard	# of Provisions	# Provisions *Met*	# Provisions *PM*	# Provisions *NM*	# *NA*	FY 2007–2008 Score (% of *Met* and *PM* Elements
Grievance and Appeal	20	12	0	1	7	92%
Quality Assurance Program	14	13	1	0	0	96%
Credentialing and Recredentialing	39	38	0	0	1	100%
EPSDT Program	10	10	0	0	0	100%
Totals	**83**	**73**	**1**	**1**	**8**	**98%**

Strengths

For the 75 applicable provisions (83 – 8 = 75), DHMC earned a score of *Met* for 73 provisions. One contract provision was deemed *Not Met* and one provision was scored *Partially Met*. DHMC demonstrated the greatest compliance with the *Credentialing and Recredentialing* and *EPSDT Program* standards, achieving scores of 100 percent for both standards. The *Quality Assurance Program* standard achieved a score of 96 percent, which also demonstrated solid performance.

Recommendations

Based on the results of the compliance review, the Department recommended the following to DHMC:

Grievance and Appeal

- DHMC must provide evidence that the appeals process was revised to ensure that requests for appeals are processed as appeals.
- Denial letters should be addressed to the member and copied to the requesting provider.

Quality Assurance Program

- DHMC should consider developing a system that compiles several sources of member information in a way that would help staff recognize a pattern from which to develop corrective action as needed.
- While DHMC used an intake form to identify persons with special health care needs, there was no evidence that the members' care was reassessed for appropriateness and quality on a periodic basis. DHMC will provide evidence of a system to identify members with special health care needs in accordance with the contract and Department rules.
- DHMC shall describe how it assesses the quality and appropriateness of members' care on an ongoing basis and document a method to identify members who attain the definitional status of special health care needs after the intake assessment.

EPSDT Program

- DHMC should work with the Department to find a method to ensure that routine pediatric screening services such as routine dental appointments, hearing, and vision examinations are tracked according to the established periodicity schedule, even if those services are delivered out of network.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of DHMC's compliance monitoring site review results related to the domains of quality, timeliness, and access.

- **Quality:** All of the compliance monitoring site review standards were related to quality. Overall, DHMC had a 98 percent score, with scores of 100 percent for the *Credentialing and Recredentialing* and *EPSDT Program* standards. The plan also demonstrated solid performance on the Quality Assurance Program standards.
- **Timeliness and Access:** The EPSDT standard contained elements relative to timeliness and access in addition to quality. DHMC's score of 100 percent demonstrated an area of strength across the three domains.

Rocky Mountain Health Plans

Findings

Table 3-2 presents the number of provisions for each of the four standards, the number of provisions assigned each score (*Met*, *PM*, *NM*, or *NA*), and the overall compliance score for the current year (FY 2006–2007).

Table 3-2—Summary of Scores for the Standards for FY 2007–2008 *for* RMHP

Description of Standard	# of Provisions	# Provisions *Met*	# Provisions *PM*	# Provisions *NM*	# *NA*	FY 2007–2008 Score (% of *Met* and *PM* Elements)
Grievance and Appeal	20	13	1	0	6	96%
Quality Assurance Program	14	14	0	0	0	100%
Credentialing and Recredentialing	39	37	1	0	1	98%
EPSDT Program	10	10	0	0	0	100%
Totals	**83**	**74**	**2**	**0**	**7**	**98%**

Strengths

For the 76 applicable provisions (83 – 7 = 76), RMHP earned a score of *Met* for 74 provisions, and two provisions were scored *Partially Met*. No provisions received a score of *Not Met*. RMHP's overall score for the site review was 98 percent. RMHP demonstrated full compliance with the 14 provisions reviewed for the Quality Assurance Program and with the EPSDT Program provisions. RMHP demonstrated solid performance on the other two standards, achieving a score of 96 percent for *Grievance and Appeal* and 98 percent for *Credentialing and Recredentialing*.

Recommendations

Based on the results of the compliance review, the Department recommended the following for RMHP:

Grievance and Appeal

- Provide evidence that grievance issues are being categorized as quality-of-care issues appropriately.
- Closure letters must be sent to members once a grievance is resolved and should clarify to the member how the grievance is being handled.

Quality Assurance Program

- RMHP did not have a formal system in place to recognize a pattern of complaints. RMHP should consider developing a system that compiles several sources of member information in a way that would help staff recognize a pattern in order to develop corrective action as necessary.

Credentialing and Recredentialing

- RMHP should provide evidence of a mechanism to deny claims for non-waivered lab codes from providers who are not CLIA certified.
- RMHP should change the language in its policies and procedures to clarify that the plan will not discriminate against providers that specialize in conditions requiring costly treatment.

EPSDT Program

- RMHP should work with the Department to find a method to ensure that routine pediatric screening services (such as routine dental appointments, hearing, and vision examinations) are tracked according to the established periodicity schedule, even if those services are delivered out of network.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of RMHP's compliance monitoring site review results related to the domains of quality, timeliness, and access.

- **Quality:** All of the compliance monitoring site review standards were related to quality. Overall, RMHP scored 98 percent, with scores of 100 percent for the *Quality Assurance Program* and *EPSDT Program* standards.
- **Timeliness and Access:** The EPSDT standard contained elements relative to timeliness and access as well as quality. RMHP's score of 100 percent demonstrated an area of strength across the three domains.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Compliance Monitoring Site Reviews

Table 3-3 shows the overall statewide average for each standard followed by conclusions drawn from the results of the compliance monitoring activity. Appendix F contains summary tables displaying the detailed site review scores for the standards by health plan and the statewide average.

Table 3-3—Summary of Data From the Review of Standards

Standards	FY 2007–2008 Statewide Average*
Grievance and Appeal	94%
Quality Assurance Program	98%
Credentialing and Recredentialing	99%
EPSDT Program	100%
Overall Statewide Compliance Score for Standards	**98%**

* Statewide average rates are weighted averages formed by summing the individual numerators and dividing by the sum of the individual denominators

- **Quality:** All of the compliance monitoring site review standards were related to quality. The overall statewide average score of 98 percent demonstrates very strong performance by the health plans.
- **Timeliness and Access:** The EPSDT standard contained elements relative to quality as well as to timeliness and access. The overall statewide score for this standard was 100 percent, which demonstrated an area of statewide strength.

Statewide recommendations (i.e., those in common across the two plans) include:

Grievance and Appeal

- Development of a method to compile member information from various sources to recognize patterns and implement a corrective action strategy as necessary.

EPSDT Program

- Collaboration between the Department and health plans to find a method to ensure that routine pediatric screening services such as dental, hearing, and vision examinations are tracked according to the established periodicity schedule, even if those services are delivered out of network.

Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements. DHMC and RMHP had existing business relationships with licensed organizations that conducted HEDIS audits for their other lines of business. The Department allowed the health plans to use their existing auditors. Although HSAG did not audit all of the health plans, HSAG did review the audit reports produced by the other licensed organizations. HSAG did not discover any questionable findings or inaccuracies in the reports and, therefore, agreed that these reports were an accurate representation of the health plans.

To make overall assessments about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the measures to one or more of the three domains as depicted in Table B-1 in Appendix B. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

When drawing conclusions regarding strengths and opportunities for improvement, HSAG considered HEDIS specification changes, where appropriate, and noted these in the report. The report does not provide FY 2006–2007 data for *Adults' Access to Preventive/Ambulatory Health Services, Use of Services: Inpatient Utilization—General Hospital Acute Care, Use of Services: Ambulatory Care,* and *Cholesterol Management for People With CV Conditions* (changed in 2007) because the Department did not require data.

The following measures contained HEDIS specification changes in 2008: *Childhood Immunization Status, Follow-Up Care for Children Prescribed ADHD Medication, Annual Monitoring for Patients on Persistent Medications, Prenatal and Postpartum Care, Use of Services: Ambulatory Care, Use of Services: Inpatient Utilization—General Hospital Acute Care.*

Denver Health Medicaid Choice

Findings

Table 3-4 displays the rates and audit results for DHMC for each performance measure. Specification changes made to four of the seven measures reported for the previous measurement year precluded a direct year-to-year comparison. More specifically, changes in the HEDIS 2008 specifications for *Childhood Immunization Status* (*Combo #2* and *#3*), *Timeliness of Prenatal Care*, and *Postpartum Care* involved addition and deletion of procedure and/or diagnosis codes. The changes likely resulted in changes in rates not directly comparable to previous year's rates or national benchmarks. Consequently, the table displays the rates for these measures for informational purposes only.

Table 3-4—Review Results and Audit Designation *for* DHMC

Performance Measures	Rate		2007 HEDIS Percentile Ratings	Audit Designation	
	FY 2006–2007	FY 2007–2008		FY 2006–2007	FY 2007–2008
Childhood Immunization Status					
Combo #2	84.78%	85.16%	>90th	R	R
Combo #3	83.70%	84.18%	>90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	61.11%	63.11%	50th-75th	R	R
Well-Child Visits 3–6 Years of Life	68.61%	56.93%	10th-25th	R	R
Adolescent Well-Care Visits	35.28%	31.85%	10th-25th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	—	66.11%	<10th	—	R
45–64 Years	—	68.69%	<10th	—	R
65+ Years	—	56.36%	<10th	—	R
Timeliness of Prenatal Care	77.39%	82.73%	25th-50th	R	R
Postpartum Care	33.91%	55.23%	25th-50th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	—	9.74	75th-90th	—	R
Days (Per 1,000 Member Months)	—	39.66	75th-90th	—	R
Average Length of Stay	—	4.07	75th-90th	—	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	—	246.58	10th-25th	—	R
ED Visits	—	36.29	10th-25th	—	R
Ambulatory Surgery/Procedures	—	3.44	10th-25th	—	R
Observation Room Stays Resulting in Discharge	—	1.60	50th-75th	—	R
Cholesterol Management for People With CV Conditions (changed in 2007)					
LDL-C Screening Performed	—	70.59%	10th-25th	—	R
LDL-C Control (< 100 mg/dL)	—	50.98%	75th-90th	—	R

Table 3-4—Review Results and Audit Designation *for* DHMC					
Performance Measures	Rate		2007 HEDIS Percentile Ratings	Audit Designation	
	FY 2006–2007	FY 2007–2008		FY 2006–2007	FY 2007–2008
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	—	16.22%	<10th	—	R
Continuation and Maintenance (C&M) Phase	—	NA		—	R
Annual Monitoring for Patients on Persistent Medications	—	77.28%	25th-50th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.

Strengths

Overall, DHMC showed strong results for performance measures. All DHMC's performance measures received an audit result of *Reportable* for the current measurement cycle. Rates for five of seven measures with both previous and current measurement results increased, with two showing an increase by at least 5 percentage points: *Timeliness of Prenatal Care* (5.34 percentage points) and *Postpartum Care* (21.32 percentage points). However, except for *Well-Child Visits in the First 15 Months of Life (6+ Visits),* HEDIS specifications changed for these measures. Rates from the previous measurement cycle were not directly comparable to those from the current year. The *Childhood Immunization Status (Combo #2* and *#3)* measures ranked above the 90th percentile of HEDIS 2007 national rates and demonstrated DMHC's strength.

Recommendations

Results of DMHC's performance measures yielded several opportunities for improvement. Two comparable measures (*Well-Child Visits 3-6 Years of Life* and *Adolescent Well-Care Visits*) declined in performance from the previous measurement cycle. In addition, four measures ranked below the national 10th percentile, with three of them associated with *Adults' Access to Preventive/Ambulatory Health Services*. The fourth measure was *Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase*.

Based on the results of this year's performance measure validation findings, recommendations for improving DHMC's performance include:

- Implementing quality strategies to improve the rate for *Well-Child Visits 3-6 Years of Life*. Potential strategies could include increased member and provider education on the importance of well-child visits.
- Implementing quality improvement strategies to improve the rate for *Adolescent Well-Care Visits*. Increased member education activities could include developing a statement for the new member welcome letter that stresses the importance of well-care visits.

- Implementing quality improvement strategies to improve the rate for *Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase*.
- Implementing quality strategies tailored to specific age or gender groups to improve the rate for *Adult's Access to Preventive Care/Ambulatory Care*.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, DHMC improved on the majority of measures reported for both previous and current measurement cycles. In addition, ~~five~~ two of the measures reported for the current measurement cycle exceeded the 2007 HEDIS national Medicaid 90th percentile. The following is a summary assessment of DMHC's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** DHMC's rates in the quality domain demonstrated mixed performance. Although rates for five of the seven measures with previous and current measurement years' results increased and two decreased, specification changes in four of these measures precluded any year-to-year comparison and subsequent assessment of performance for these measures. Overall, among those measures without specification changes, only one demonstrated an improvement (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*, which increased 2 percentage points). Two quality-related measures ranked above the 2007 HEDIS national Medicaid 90th percentile.
- **Timeliness:** All seven timeliness measures reported results from the previous measurement cycle, with increased rates for five measures. However, specification changes in four of these measures precluded any year-to-year comparison and subsequent assessment of performance for these measures. Overall, among those measures without specification changes, only one demonstrated an improvement (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*, which increased 2 percentage points). Measures that declined in performance included *Well-Child Visits 3-6 Years of Life* (which decreased by 11.68 percentage points) and *Adolescent Well-Care Visits* (which decreased by 3.43 percentage points). Both of these measures also ranked in the 2007 HEDIS 10th–25th percentile range. These results demonstrated significant opportunities for DHMC to improve its performance on well-child visit measures for children 3 years of age and older.
- **Access:** DHMC's performance in the access domain demonstrated mixed performance. The increased rates shown in *Timeliness of Prenatal Care* and *Postpartum Care* might not indicate performance improvement because of changes in the HEDIS 2008 specifications. DHMC's performance on the *Adults' Access to Preventive/Ambulatory Health Services* measures ranked below the national 10th percentile.

Rocky Mountain Health Plans

Findings

Table 3-5 displays the rates and audit results for RMHP for each performance measure. The current measurement year reported rates for 12 measures. Specification changes made to 4 of the 7 measures reported for the previous measurement year precluded any year-to-year comparison. More specifically, changes in the HEDIS 2008 specifications for *Childhood Immunization Status* (*Combo #2* and *#3*), *Timeliness of Prenatal Care*, and *Postpartum Care* involved addition and deletion of procedure and/or diagnosis codes. The changes likely resulted in changes in rates not directly comparable to previous years' rates or national benchmarks. Consequently, the table displays rates for these measures for informational purposes only.

Table 3-5—Review Results and Audit Designation *for* RMHP

Performance Measures	Rate		2007 HEDIS Percentile Ratings	Audit Designation	
	FY 2006–2007	FY 2007–2008		FY 2006–2007	FY 2007–2008
Childhood Immunization Status					
Combo #2	74.46%	81.50%	75th-90th	R	R
Combo #3	68.01%	75.86%	>90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	27.66%	30.60%	<10th	R	R
Well-Child Visits 3–6 Years of Life	67.09%	59.55%	10th-25th	R	R
Adolescent Well-Care Visits	39.48%	40.84%	25th-50th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	—	83.71%	50th-75th	—	R
45–64 Years	—	87.99%	50th-75th	—	R
65+ Years	—	94.98%	>90th	—	R
Timeliness of Prenatal Care	97.08%	97.12%	>90th	R	R
Postpartum Care	75.91%	72.84%	>90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	—	14.80	>90th	—	R
Days (Per 1,000 Member Months)	—	48.45	>90th	—	R
Average Length of Stay	—	3.27	10th-25th	—	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	—	440.63	>90th	—	R
ED Visits	—	54.09	25th-50th	—	R
Ambulatory Surgery/Procedures	—	12.17	>90th	—	R
Observation Room Stays Resulting in Discharge	—	1.17	25th-50th	—	R
Cholesterol Management for People With CV Conditions (changed in 2007)					
LDL-C Screening Performed	—	74.39%	25th-50th	—	R
LDL-C Control (< 100 mg/dL)	—	57.32%	>90th	—	R

Table 3-5—Review Results and Audit Designation *for* RMHP					
Performance Measures	Rate		2007 HEDIS Percentile Ratings	Audit Designation	
	FY 2006–2007	FY 2007–2008		FY 2006–2007	FY 2007–2008
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	—	NB		—	R
Continuation and Maintenance (C&M) Phase	—	NB		—	R
Annual Monitoring for Patients on Persistent Medications	—	65.20%	<10th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.
NB is shown when the required benefit was not offered for the report measure.

Strengths

Overall, RMHP showed strong results for performance measures. All of RMHP's performance measures received an audit result of *Reportable* for the current measurement cycle. Seven of those measures were also *Reportable* in the previous measurement cycle. Five of seven measures with previous and current measurement results showed an increase in rates, with two having an increase by at least 5 percentage points: *Childhood Immunization Status—Combo #2* (7.04 percentage points) and *Combo #3* (7.85 percentage points). However, except for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Adolescent Well-Care Visits*, HEDIS specifications have changed for these measures. Rates from the previous measurement cycle were not directly comparable to those from the current year. Nine of the current measures ranked above the 90th percentile of the 2007 HEDIS national Medicaid rates. These measures were: *Childhood Immunization Status (Combo #3), Adults' Access to Preventive/Ambulatory Health Services (65+ Years), Timeliness of Prenatal Care, Postpartum Care, Inpatient Discharges per 1,000 Member Months, Inpatient Days per 1,000 Member Months, Outpatient Visits per 1,000 Member Months, Ambulatory Surgery/Procedures per 1,000 Member Months, and LDL-Control (< 100 mg/dL) Cholesterol Management for People With CV Conditions.*

Recommendations

Results of RMHP's performance measures yielded several opportunities for improvement. Two comparable measures declined in performance from the previous measurement cycle, with one rate having decreased more than 5 percentage points (*Well-Child Visits 3–6 Years of Life*, which decreased 7.54 percentage points). Two of the measures were below the national 10th percentile: *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Annual Monitoring for Patients on Persistent Medications.*

Based on the results of this year's performance measure validation findings, recommendations for improving RMHP's performance include:

- Implementing quality strategies to improve the rate for *Well-Child Visits in the First 15 Months of Life (6+Visits)* and *Well-Child Visits 3–6 Years of Life*. Potential strategies could include increased member and provider education on the importance of well-child visits.
- Implementing quality strategies to improve the rate for *Annual Monitoring for Patients on Persistent Medications*.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, RMHP improved on the majority of measures reported for both previous and current measurement cycles. Three of the comparable measures and an additional six measures reported for the current measurement cycle exceeded the 2007 HEDIS national Medicaid 90th percentile. The following is a summary assessment of RMHP's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** RMHP's rates in the quality domain demonstrated mixed performance. Rates for five of the seven comparable measures increased while two rates decreased from the previous to the current measurement cycle. However, because of specification changes, an improvement or decline could only be concluded from those measures that did not experience changes in their HEDIS 2008 specifications. Overall, the rate for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* increased by 2.94 percentage points. Despite this improvement, RMHP's current performance was still below the national 10th percentile. The rate for *Adolescent Well-Care Visits* had a slight increase of 1.36 percentage points. Significant decline was noted for *Well-Child Visits 3–6 Years of Life* with a decrease of 7.54 percentage points from the previous measurement year, causing RMHP to have a lower percentile rank in the current measurement year. RMHP's performance on *Annual Monitoring for Patients on Persistent Medications* ranked below the national 10th percentile.
- **Timeliness:** All seven timeliness measures had comparable data from the previous measurement cycle, with rates for five of the seven comparable measures increasing and two decreasing from the previous to the current measurement cycle. However, because of specification changes, improvement or decline could be determined only in measures that did not experience changes in their HEDIS 2008 specifications. Overall, the rate for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* increased by 2.94 percentage points. Despite this improvement, RMHP's current performance was still below the national 10th percentile. The rate for *Adolescent Well-Care Visits* had a slight increase of 1.36 percentage points. The rate for *Well-Child Visits 3–6 Years of Life* declined significantly, decreasing 7.54 percentage points from the previous measurement year and causing RMHP to have a lower percentile rank in the current measurement year.
- **Access:** RMHP's performance in the access domain demonstrated mixed performance. HEDIS specification changes to the two access-related measures with previous-year data precluded any year-to-year comparison and assessment. Among those access-related measures reported the first time for the current measurement year, only one measure (*Adults' Access to Preventive/Ambulatory Health Services, 65+ Years*) ranked above the national 90th percentile.

Primary Care Physician Program

HSAG conducted an NCQA HEDIS Compliance Audit for PCPP. The NCQA HEDIS Compliance Audit followed NCQA audit methodology. This audit methodology complied with both NCQA and CMS specifications and allowed for a complete and reliable evaluation of the health plan. The auditor's responsibility was to express an opinion on the performance report based on an examination using NCQA procedures that the auditor considered necessary to obtain a reasonable basis for rendering an opinion.

Table 3-6 displays the key types of data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-6—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Baseline Assessment Tool (BAT)	CY 2007
Certified Software Report	CY 2007
Performance Measure Reports	CY 2007
Supporting Documentation	CY 2007
On-site Interviews and Demonstrations	CY 2007

Note: CY stands for calendar year.

HSAG gave one of four audit findings to each measure: *Reportable* (R), *Not Applicable* (NA), *No Benefit* (NB), or *Not Reportable* (NR) based on NCQA standards.

Findings

Table 3-7 displays the rates and audit results for PCPP for each performance measure. The current measurement year reported rates for 12 measures. Specification changes made to 4 of the 7 measures reported for the previous measurement year precluded any year-to-year comparison. More specifically, changes in the HEDIS 2008 specifications for *Childhood Immunization Status* (*Combo #2* and *#3*), *Timeliness of Prenatal Care*, and *Postpartum Care* involved addition and deletion of procedure and/or diagnosis codes. The changes likely resulted in changes in rates not directly comparable to previous years' rates or national benchmarks. Consequently, the table displays rates for these measures for informational purposes only.

Table 3-7—Review Results and Audit Designation *for* PCPP					
Performance Measures	Rate		2007 HEDIS Percentile Ratings	Audit Designation	
	FY 2006–2007	FY 2007–2008		FY 2006–2007	FY 2007–2008
Childhood Immunization Status					
Combo #2	49.39%	78.60%	50th-75th	R	R
Combo #3	41.72%	69.82%	50th-75th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	35.53%	56.48%	25th-50th	R	R
Well-Child Visits 3–6 Years of Life	21.12%	42.58%	<10th	R	R
Adolescent Well-Care Visits	27.49%	15.16%	<10th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	—	64.59%	<10th	—	R
45–64 Years	—	63.67%	<10th	—	R
65+ Years	—	15.15%	<10th	—	R
Timeliness of Prenatal Care	54.01%	63.45%	<10th	R	R
Postpartum Care	50.61%	65.27%	50th-75th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	—	8.29	50th-75th	—	R
Days (Per 1,000 Member Months)	—	40.94	75th-90th	—	R
Average Length of Stay	—	4.94	>90th	—	R
Use of Services: Ambulatory Care(Per 1000 Member Months)					
Outpatient Visits	—	298.67	25th-50th	—	R
ED Visits	—	50.18	25th-50th	—	R
Ambulatory Surgery/Procedures	—	7.14	75th-90th	—	R
Observation Room Stays Resulting in Discharge	—	1.43	50th-75th	—	R
Cholesterol Management for People With CV Conditions (changed in 2007)					
LDL-C Screening Performed	—	69.23%	10th-25th	—	R
LDL-C Control (< 100 mg/dL)	—	24.48%	10th-25th	—	R
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	—	33.86%	50th-75th	—	R
Continuation and Maintenance (C&M) Phase	—	31.25%	25th-50th	—	R
Annual Monitoring for Patients on Persistent Medications	—	79.96%	50th-75th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.

Strengths

Overall, PCPP showed very strong results for performance measures. All of PCPP's performance measures received an audit result of *Reportable*. Six of the seven measures with previous and current measurement results had a rate increase of least 5 percentage points, with the largest

increases in the *Childhood Immunization Status* measures (more than 25 percentage points for each measure). Nonetheless, except for *Well-Child Visits in the First 15 Months of Life (6+ Visits)*, *Well-Child Visits 3–6 Years of Life*, and *Adolescent Well-Care Visits*, HEDIS specifications have changed for these measures. Rates from the previous measurement cycle were not directly comparable to those from the current year. Among those measures that had comparable results from both the previous and current measurement cycles, both *Well-Child Visits* measures improved significantly. One measure that was comparable to the 2007 HEDIS national Medicaid percentiles had a rate above 90th percentile: *Average Length of Stay for Inpatient General Hospital Acute Care*.

Recommendations

Results of PCPP's performance measures yielded several opportunities for improvement. Although *Adolescent Well Care* was the only measure with a decline in performance from the previous measurement cycle, the decline (i.e., 12.33 percentage points) was more than 5 percentage points. In addition, despite improvement from the previous cycle, six of the measures were below the national 10th percentile. They were *Well-Child Visits 3–6 Years of Life, Adolescent Well-Care Visits, Adults' Access to Preventive/Ambulatory Health Services* (all 3 age groups), and *Timeliness of Prenatal Care.*

Based on the results of this year's performance measure validation findings, recommendations for improving PCPP's performance include:

- Implementing quality strategies to improve the rate for *Well-Child Visits 3–6 Years of Life*. A potential strategy could include increased member and provider education on the importance of well-child visits.
- Similar quality improvement strategies could be applied to adolescent members to improve the rate for *Adolescent Well-Care Visits*. Increased member education activities could include developing a new member welcome letter that stresses the importance of well-care visits.
- Implementing quality improvement strategies to improve the rate for *Timeliness of Prenatal Care*. Potential actions might include increased member education on the need for timely prenatal care and increased provider training on the importance of appropriate prenatal care.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, PCPP improved on the majority of measures reported for both the previous and current measurement cycles. The following is a summary assessment of PCPP's performance measure results related to the domains of quality, timeliness, and access

- **Quality:** PCPP's rates in the quality domain demonstrated overall improvement in performance. Rates for six of the seven comparable measures increased. Although all of the comparable measures had significant changes, because of specification changes, improvement or decline could be determined only in those measures that did not experience changes in their HEDIS 2008 specifications. Rates for *Well-Child Visits in the First 15 Months of Life* (*6+ Visits*) and *3–6 Years of Life* increased by more than 20 percentage points each. Nonetheless, PCPP's performance on these measures was still below the national 50th percentile. The current rate for *Adolescent Well-Care Visits* declined by 12.33 percentage points from the previous

measurement year. For the measures reported for first time in the current measurement year, the measures for *Cholesterol Management for People with Cardiovascular Conditions* (*LDL-C Screening Performed* and *Control with < 100 mg/dL*) ranked in the national 10th–25th percentile, with the rate for *LDL-C Control with <100 mg/dL* being the lowest among the three health plans (24.48 percent versus 50.98 percent for DMHC and 57.32 percent for RMHP).

- **Timeliness:** Rates for six of the seven comparable measures increased while one decreased. Although all comparable measures had significant changes in rates, because of specification changes, improvement or decline could be determined only in those measures that did not experience changes in their HEDIS 2008 specifications. Rates for *Well-Child Visits in the First 15 Months of Life* (*6+ Visits*) and *3–6 Years of Life* increased by more than 20 percentage points each. Nonetheless, PCPP's performance on these measures was still below the national 50th percentile. The current rate for *Adolescent Well-Care Visits* declined by 12.33 percentage points from the previous measurement year. Additionally, this measure ranked below the national 10th percentile in the current measurement year.
- **Access:** PCPP demonstrated mixed performance in the access domain. Although rates for both *Timeliness of Prenatal Care* and *Postpartum Care* increased by more than 5.0 percentage points, because of specification changes, improvement or decline could be determined only in those measures that did not experience changes in their HEDIS 2008 specifications. PCPP's rates for *Adults' Access to Preventive/Ambulatory Health Services* were below the national 10th percentile.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Validation of Performance Measures

Table 3-8 provides a statewide summary of the rates for the performance measures for FY 2006–2007 and FY 2007–2008. Changes were made to the HEDIS 2008 specifications for the following measures reported also for the previous measurement year: *Childhood Immunization Status (Combo #2* and *#3)*, *Timeliness of Prenatal Care*, and *Postpartum Care*. The changes likely resulted in changes in rates not directly comparable to previous years' rates or national benchmarks. Consequently, the table displays the rates for these measures for informational purposes only.

Table 3-8—Statewide Summary of Rates for the Performance Measures

Performance Measures	Overall Rates		2007 HEDIS Percentile
	FY 2006–2007	FY 2007–2008	
Childhood Immunization Status			
Combo #2	69.54%	81.75%	75th-90th
Combo #3	64.48%	76.62%	>90th
Well-Child Visits in the First 15 Months of Life, 6+ Visits	41.43%	50.06%	25th-50th
Well-Child Visits 3–6 Years of Life	52.27%	53.02%	<10th
Adolescent Well-Care Visits	34.08%	29.28%	<10th
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	—	71.47%	10th-25th
45–64 Years	—	73.45%	<10th
65+ Years	—	55.50%	<10th
Timeliness of Prenatal Care	76.16%	81.10%	25th-50th
Postpartum Care	53.48%	64.45%	50th-75th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)			
Discharges (Per 1,000 Member Months)	—	10.94	75th-90th
Days (Per 1,000 Member Months)	—	43.02	>90th
Average Length of Stay	—	4.09	75th-90th
Use of Services: Ambulatory Care(Per 1,000 Member Months)			
Outpatient Visits	—	328.63	50th-75th
ED Visits	—	46.85	25th-50th
Ambulatory Surgery/Procedures	—	7.58	75th-90th
Observation Room Stays Resulting in Discharge	—	1.40	50th-75th
Cholesterol Management for People With CV Conditions (changed in 2007)			
LDL-C Screening Performed	—	71.40%	25th-50th
LDL-C Control (< 100 mg/dL)	—	44.26%	50th-75th
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	25.04%[A]	25th-50th
Continuation and Maintenance (C&M) Phase	—	31.25%[A]	25th-50th
Annual Monitoring for Patients on Persistent Medications	—	74.15%	10th-25th

— is shown when no data were available, or the measure was not reported in last year's technical report.
NA is shown when there were fewer than 30 cases in the denominator for the rate for each provider.
[A] Statewide results were calculated from DHMC and PCPP. This required benefit was not offered by RMHP for the report measure.

Strengths

Overall, the statewide results for performance measures were mixed. Although six of the seven comparable measures with rates for both the previous and current measurement years had a rate increase, not all of these measures suggested a definite improvement because of the HEDIS specification changes. Nonetheless, improvement in performance was evident in two of the three comparable measures with consistent HEDIS specifications. These measures included *Well-Child Visits in the First 15 Months of Life* (*6+ Visits*), which increased 8.63 percentage points, and *Well-Child Visits 3–6 Years of Life*, which increased 0.75 percentage points. In addition, two comparable measures (*Childhood Immunization Status Combo #2* and *#3*) ranked above the national 75th percentile for 2007.

Recommendations

Among those comparable measures with consistent HEDIS specifications, only the *Adolescent Well-Care Visits* measure declined in performance (decreasing 4.8 percentage points). Considerable opportunities for improvement also existed for the *Well-Child Visits* measures, *Timeliness of Prenatal Care*, and *Postpartum Care*, the majority of which ranked below the 50th percentile. Rankings for measures like *Well-Child Visits 3–6 Years of Life* and *Adolescent Well-Care Visits* were below the 10th percentile.

The Medicaid program also showed opportunities for improvement for several performance measures that were reported the first time in the current measurement year. Statewide rankings for *Adults' Access to Preventive/Ambulatory Health Services* and *Annual Monitoring for Patients on Persistent Medications* were below the 25th percentile. For the *Adults' Access to Preventive/Ambulatory Health Services* measures, rates for the older age groups (*45–64 Years* and *65+ Years*) were below the national 10th percentile, suggesting considerable opportunities for improvement.

Based on the results of this year's performance measure validation findings, recommendations for improving statewide performance include:

- Implementing quality strategies to improve the rates for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Well-Child Visits 3-6 Years of Life*. Potential strategies include increased member and provider education on the importance of well-child visits.
- Implementing quality strategies to improve the rate for *Adolescent Well-Care Visits*. The State may collaborate with health plans to develop posters and new Medicaid member welcome letters that stress the importance of well-care visits
- Implementing quality strategies tailored to specific age or gender groups to improve the rate for *Adult's Access to Preventive Care/Ambulatory Care*. Potential strategies include improving communication with members by sending a newsletter with annual checkup reminders and age/gender-specific information. The State may collect current practice information from health plans and providers within the State or from other states to identify any best or promising practices for improving this measure.
- Implementing quality strategies to improve the rate for *Annual Monitoring for Patients on Persistent Medications*. Potential strategies include improving communication with members by

sending annual reminders of physiologic or therapeutic monitoring tests with information about the importance of annual monitoring and the risk associated with noncompliance.

- Implementing quality improvement strategies to improve the rates for *Timeliness of Prenatal Care* and *Postpartum Care*. Potential actions include increased member education on the need for timely prenatal care and postpartum care and increased provider training on the importance of appropriate prenatal and/or perinatal care.

Summary Assessment Related to Quality, Timeliness, and Access

Since HEDIS specification changes occurred in four of the seven comparable measures, assessments of improvement were only applicable to three comparable measures. Compared to the previous measurement years, two of these statewide performance measures improved and one measure declined. The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** Results in the quality domain demonstrated mixed performance. Although a majority of the rates increased for measures with previous measurement results, HEDIS specification changes precluded any assessment of performance improvement for these measures. Nonetheless, two of the three measures with applicable year-to-year comparison data showed improvement, one of which (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*) increased 8.63 percentage points. On the other hand, the rate for *Adolescent Well-Care Visits* decreased by 4.8 percentage points. In addition, when comparing the current statewide quality measures with the 2007 HEDIS Medicaid rates, three measures (*Well-Child Visits 3–6 Years of Life*, *Adolescent Well-Care Visits,* and *Annual Monitoring for Patients on Persistent Medications*) ranked below the 25th percentile.
- **Timeliness:** Results in the timeliness domain demonstrated mixed performance. HEDIS 2008 specification changes prevented a comparison of performance in four of the seven measures with rates from the prior year and current year. Nonetheless, performance improved for *Well-Child Visits in the First 15 Months of Life* (*6+ Visits*) and *Well-Child Visits 3–6 Years of Life*, with rates that increased by 8.63 and 0.75 percentage points, respectively). On the other hand, the rate for *Adolescent Well-Care Visits* decreased by 4.8 percentage points. Comparing results of the current measurement year to the HEDIS Medicaid national rates, the State Medicaid program maintained a relatively high ranking for the two *Childhood Immunization Status* measures, with rates above the 75th percentile. Measures related to *Well-Child* and *Well-Care* visits, on the other hand, ranked below the 50th percentile for 2007.
- **Access:** Statewide performance in the access domain demonstrated opportunities for improvement for the Medicaid program. Although rates for *Timeliness of Prenatal Care* and *Postpartum Care* increased from the previous measurement year, these measures had HEDIS specification changes that prevented a direct year-to-year rate comparison. Nonetheless, the higher rate reported in the current measurement year for *Postpartum Care* had improved the Medicaid program's relative ranking from the 25th–50th percentile last year to the 50th–75th percentile this year. Colorado ranked below the Medicaid 2007 national 25th percentile for *Adults' Access to Preventive/Ambulatory Health Services,* indicating opportunities for improvement.

Validation of Performance Improvement Projects

HSAG validated PIPs for DHMC and RMHP only. PCPP did not participate in this activity because it is not required of a primary care case management (PCCM) plan. For each participating health plan, HSAG performed validation activities on two PIPs. HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and evaluation. For ongoing PIP studies, the health plan updated the form to include new data to support activities from the previous validation cycle. HSAG obtained data needed to conduct the PIP validation from the health plan's PIP Summary Form. This form provided detailed information about each health plan's PIP as it related to the 10 CMS protocol activities reviewed and evaluated by HSAG. The HSAG PIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

The HSAG PIP Review Team provided on-site technical assistance to the MCOs on August 24, 2007. During this on-site meeting, HSAG conducted a presentation on how to complete the HSAG PIP Summary Form using CMS Protocols as a guide. The presentation outlined the PIP study phases: study design, study implementation, and quality outcomes achieved. HSAG PIP Review Team members described to meeting participants the submission process and reviewed the current timeline for the annual submission and validation cycle. HSAG provided ongoing technical assistance to the plans throughout the contract year. HSAG provided technical assistance on PIPs by responding to e-mail inquiries or scheduling conference calls with the plans.

In addition to the validation status, each PIP was given an overall percentage score for all evaluation elements *Met* (including critical elements) and a percentage score for critical elements *Met.* HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- *Met*: Confidence/high confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain.

Appendix C contains further details about the EQR validation of PIP activities.

Denver Health Medicaid Choice

Findings

DHMC conducted two PIPs: *Childhood Immunizations* and *Member Satisfaction With Access to Pharmacy Services*. Both PIPs were continued from the prior year.

For the FY 2007–2008 *Childhood Immunizations* PIP, HSAG reviewed Activities I through IX. Table 3-9 and Table 3-10 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-9—PIP Validation Scores *for* Childhood Immunizations *for* DHMC

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	11	0	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	3	0	0	1	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	1	2	1	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**40**	**2**	**1**	**9**	**11**	**9**	**0**	**0**	**2**

Table 3-10—FY 2005–2006 and FY 2006–2007 Overall PIP Validation Scores and Validation Status *for* Childhood Immunizations *for* DHMC		
	FY 2006–2007	FY 2007–2008
Percentage Score of Evaluation Elements *Met**	**100%**	**93%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score for all evaluation elements is calculated by dividing the total evaluation elements *Met* by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

****Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the *Member Satisfaction With Access to Pharmacy Services* PIP, HSAG reviewed Activities I through IX. Table 3-11 and Table 3-12 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-11—PIP Validation Scores *for* Member Satisfaction With Access to Pharmacy Services *for* DHMC

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX. Real Improvement Achieved	4	2	2	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**42**	**2**	**0**	**8**	**11**	**10**	**0**	**0**	**1**

Table 3-12—FY 2005–2006 and FY 2006–2007 Overall PIP Validation Scores and Validation Status *for* Member Satisfaction With Access to Pharmacy Services *for* DHMC		
	FY 2006–2007	FY 2007–2008
Percentage Score of Evaluation Elements *Met**	**100%**	**95%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score for all evaluation elements is calculated by dividing the total evaluation elements *Met* by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*.
** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
****Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

DHMC's *Childhood Immunization* PIP successfully addressed access to, and the quality of, care to eligible members. DHMC demonstrated strength in the ability to apply the CMS protocols to its PIP processes as evidenced by receiving 100 percent for all critical elements *Met* for both the previous year and current year. Four of the nine study indicators reported in this PIP met or exceeded the goal of reaching the NCQA 90th percentile. DHMC completed Activities I through IX, receiving an overall score of 93 percent.

For its *Member Satisfaction With Access to Pharmacy Services* PIP, DMHC received a critical element score of 100 percent for both the previous year and current year. Like the *Childhood Immunization* PIP, this PIP successfully addressed access to, and the timeliness and quality of, care and services to eligible members. The study topic and question were clearly and accurately stated to set and maintain the focus of the study. Baseline and first remeasurement results were reported with improvement across most study indicators. DHMC completed Activities I through IX, receiving an overall score of 95 percent.

Recommendations

In Activity II of the *Childhood Immunization* PIP, the study question was stated as a "hypothesis" rather than as a study question. HSAG's PIP Review Team recommended that in future submissions of the PIP DHMC make this "hypothesis" the main study question, ensuring that the question is in the format: "Does doing X result in Y?" Activity IX of the *Childhood Immunization* PIP had two *Partially Met* evaluation elements and one *Not Met* evaluation element. In this activity, rates for five of the nine study indicators demonstrated improvement from Baseline to the first remeasurement; however, there was no statistical evidence that this improvement was true improvement. The HSAG PIP Review Team suggested that DHMC perform a second causal/barrier analysis to assess for necessary changes so that DHMC can achieve its desired outcomes for all study indicators. Based on the results of the causal/barrier analysis, DHMC should make revisions to existing interventions or implement new improvement strategies.

While most of the study indicators in the *Member Satisfaction With Access to Pharmacy Services* PIP improved from Baseline to the first remeasurement, some study indicators declined in performance. The HSAG PIP Review Team recommended that DHMC re-evaluate the interventions and perform a causal/barrier analysis to identify barriers that may be preventing improvement. Once DHMC identifies the barriers the health plan can make necessary revisions to the existing interventions or implement new improvement strategies.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of DHMC's two PIPs, *Childhood Immunizations* and *Member Satisfaction With Access to Pharmacy Services,* was to improve both the quality of, and access to, care and services, the EQR activities related to PIPs were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, the summary assessment of DHMC's PIP validation results related to the domain of quality.

Overall, DHMC's processes for conducting valid PIPs were strong. Both PIPs received a validation status of *Met,* with HSAG having confidence in the reported results. HSAG has identified opportunities for improvement for both PIPs and has provided recommendations to DHMC on how to strengthen the current PIP structure and achieve improvement across all study indicators.

Rocky Mountain Health Plans

Findings

RMHP conducted two PIPs (i.e., *Improving Postpartum Visit Rates* and *Improving Well-Care Rates for Children and Adolescents*). Both PIPs were continued from the prior year.

For the *Improving Postpartum Visit Rates* PIP, HSAG reviewed Activities I through X. Table 3-13 and Table 3-14 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-13—PIP Validation Scores *for* Improving Postpartum Visit Rates *for* RMHP

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	11	0	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	3	0	0	1	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX. Real Improvement Achieved	4	1	2	1	0	No Critical Elements				
X. Sustained Improvement Achieved	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**48**	**2**	**1**	**2**	**11**	**11**	**0**	**0**	**0**

Table 3-14—FY 2005–2006 and FY 2006–2007 Overall PIP Validation Scores and Validation Status *for* Improving Postpartum Visit Rates *for* RMHP		
	FY 2006–2007	FY 2007–2008
Percentage Score of Evaluation Elements *Met**	**100%**	**94%**
Percentage Score of Critical Elements *Met**	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score for all evaluation elements is calculated by dividing the total evaluation elements *Met* by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

****Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the *Improving Well-Care Rates for Children and Adolescents* PIP, HSAG reviewed Activities I through VIII. Table 3-15 and Table 3-16 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3-15—PIP Validation Scores *for* Improving Well-Care Rates for Children and Adolescents *for* RMHP

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**29**	**0**	**0**	**19**	**11**	**8**	**0**	**0**	**3**

Table 3-16—FY 2005–2006 and FY 2006–2007 Overall PIP Validation Scores and Validation Status *for* Improving Well-Care Rates for Children and Adolescents *for* RMHP		
	FY 2006–2007	**FY 2007–2008**
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met**	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score for all evaluation elements is calculated by dividing the total evaluation elements *Met* by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

****Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

RMHP's *Improving Postpartum Visit Rates* PIP successfully addressed access to, and timeliness of, care and services. RMHP demonstrated strength in the ability to apply the CMS protocols to its PIP processes as evidenced by receiving 100 percent for all critical elements *Met* for both the previous year and current year. RMHP has completed all activities and received an overall score of 94 percent for evaluation elements *Met*. Although RMHP's performance declined in the second remeasurement period, PIP results have improved since Baseline and remained above the NCQA 90th percentile.

RMHP's *Well-Care Rates for Children and Adolescents* PIP clearly and accurately stated the study topic and question and successfully addressed access to, and timeliness of, care and services. RMHP has demonstrated consistent performance on its *Well-Care Rates for Children and Adolescents* PIP, receiving a score of 100 percent for all critical and noncritical evaluation elements and a validation status of *Met* for both the previous year and current year.

Recommendations

Based on the lack of statistically significant change in RMHP's *Improving Postpartum Visit Rates* PIP, the HSAG PIP Review Team suggested that RMHP perform a second causal/barrier analysis for the *Improving Postpartum Visit Rates* PIP to assess necessary changes that could be made to existing interventions or implementation of new interventions.

For the *Improving Well-Care Rates for Children and Adolescents* PIP, HSAG recommended that RMHP provide the year of the HEDIS technical specifications used to define its study population in the PIP documentation. The data collection timelines should be complete date ranges and the reported results should be consistent throughout the PIP Summary Form.

Summary Assessment Related to Quality, Timeliness, and Access

The focus of RMHP's *Improving Well-Care Rates for Children and Adolescents* PIP was to improve quality, and the focus of the *Improving Postpartum Visit Rates* PIP was to improve both the quality of and access to care and services. The EQR activities related to PIPs, however, were

designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, the summary assessment of RMHP's PIP validation results related to the domain of quality.

Overall, RMHP had effective processes for conducting valid PIPs. Both PIPs received a validation status of *Met*, with HSAG having confidence in the reported results. HSAG has identified opportunities for improvement for both PIPs and has provided recommendations to RMHP on how to strengthen the current PIP structures and achieve improvement across all study indicators.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Validation of Performance Improvement Projects

Table 3-17—Summary of Data From Validation of Performance Improvement Projects

Validation Activity	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
I. Appropriate Study Topic	4/4	4/4	4/4	4/4
II. Clearly Defined, Answerable Study Question	4/4	4/4	4/4	4/4
III. Clearly Defined Study Indicator(s)	4/4	4/4	4/4	4/4
IV. Use a Representative and Generalizable Study Population	4/4	4/4	4/4	4/4
V. Valid Sampling Techniques	4/4	*2/2	4/4	2/2
VI. Accurate/Complete Data Collection	4/4	4/4	4/4	4/4
VII. Appropriate Improvement Strategies	2/2	4/4	No Critical Elements	
VIII. Sufficient Data Analysis and Interpretation	2/2	4/4	0/0	0/0
IX. Real Improvement Achieved	0/0	0/3	No Critical Elements	
X. Sustained Improvement Achieved	0/0	1/1	No Critical Elements	

*The scoring methodology for Activity V. Valid Sampling Techniques was changed. If sampling was not used, the evaluation element received a *Not Applicable*.

Table 3-17 provides a year-to-year comparison of the total number of PIPs submitted by the health plans that achieved a score of *Met* for all evaluation elements and for all critical elements by activity. In both years, all four PIPs that were submitted received scores of *Met* for all evaluation elements and for all critical elements for Activity I, represented by 4/4. In FY 2007–2008, three PIPs had progressed to Activity IX. While some evaluation elements for these three PIPs may have been scored *Met*, *Partially Met* or *Not Met*, none of the three PIPs received a *Met* score for all evaluation elements in that activity, represented as 0/3.

As previously discussed, the EQR activities related to PIPs were designed to evaluate the validity and quality of health plan processes for conducting valid PIPs. Therefore, the summary assessment of the health plans' PIP validation results related to the domain of quality.

Overall, the health plans were effective in using the CMS protocols to conduct PIPs. Both health plans have achieved improvement or sustained improvement in some of the study indicators. The HSAG PIP Review Team has provided recommendations to DHMC and RMHP that will help both plans achieve their desired outcomes for all study indicators.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data.

DHMC and RMHP were responsible for conducting annual CAHPS surveys. The health plans forwarded results to HSAG for analysis. HSAG conducted the surveys on behalf of the Department for PCPP.

For each of the four global ratings, the rates were based on responses by members who chose a value of 9 or 10 on a scale of 0 to 10. For the composites, rates were based on responses by members who chose "Always," "Not a Problem," or "Definitely Yes." Appendix D contains additional details about the technical methods of data collection and analysis of survey data and the 2007 NCQA CAHPS national averages.

Denver Health Medicaid Choice

Findings

Table 3-18 displays the child Medicaid results achieved by DHMC for the prior year (FY 2006–2007).

Table 3-18—Child Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	82.6%	†
Getting Care Quickly	44.7%	†
How Well Doctors Communicate	68.1%	†
Courteous and Helpful Office Staff	62.2%	†
Customer Service	NA	†
Rating of Personal Doctor	70.3%	†
Rating of Specialist Seen Most Often	NA	†
Rating of All Health Care	62.4%	†
Rating of Health Plan	65.0%	†

NA indicates that the measure had fewer than 100 respondents.

† FY 2007–2008 child Medicaid data are not reportable for DHMC, as specified by the Department.

Table 3-19 displays the adult Medicaid results achieved by DHMC during the current year (FY 2007–2008) and the prior year (FY 2006–2007).

Table 3-19—Adult Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	44.5%	44.9%
Getting Care Quickly	49.3%	48.1%
How Well Doctors Communicate	72.4%	73.8%
*Customer Service**	*	NA
Shared Decision Making	53.2%	59.0%
Rating of Personal Doctor	69.4%	71.6%
Rating of Specialist Seen Most Often	56.2%	60.0%
Rating of All Health Care	46.1%	52.2%
Rating of Health Plan	51.4%	56.4%

NA indicates that the measure had fewer than 100 respondents.

* Due to changes in the *Customer Service* composite, the results for this measure are not comparable across the two years reported in the table, per NCQA.

Recommendations

The adult Medicaid survey results showed substantial increases for three of the measures. While the *Getting Care Quickly* results did not decrease substantially, DHMC should continue to direct quality improvement activities toward this area of care. Recommendations for improving performance include having scheduling models that allow for appointment flexibility, simplified patient flow to limit bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

Due to terms stipulated by the Department, FY 2007–2008 child Medicaid results were not reported for DHMC. Therefore, HSAG could not perform a year-to-year comparison or provide recommendations for the child Medicaid population.

For the adult Medicaid population, seven of the comparable measures' rates increased. Three of the measures' rates increased by 5 percentage points or more: *Shared Decision Making* (5.8 percentage points), *Rating of All Health Care* (6.1 percentage points), and *Rating of Health Plan* (5.0

percentage points). Furthermore, DHMC had the highest rates among the health plans for two measures: *How Well Doctors Communicate* and *Rating of Personal Doctor*.

Only one of the comparable measures decreased for the adult Medicaid population: *Getting Care Quickly* (1.2 percentage points). However, this decrease was not substantial. Four of the measures—*Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*—had the lowest rates among the health plans.

Rocky Mountain Health Plans

Findings

Table 3-20 displays the child Medicaid results achieved by RMHP for the prior year (FY 2006–2007).

Table 3-20—Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	86.7%	†
Getting Care Quickly	55.3%	†
How Well Doctors Communicate	69.2%	†
Courteous and Helpful Office Staff	71.8%	†
Customer Service	NA	†
Rating of Personal Doctor	66.1%	†
Rating of Specialist Seen Most Often	NA	†
Rating of All Health Care	65.9%	†
Rating of Health Plan	60.9%	†

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

† FY 2007–2008 child Medicaid data are not reportable for RMHP, as specified by the Department.

Table 3-21 displays the adult Medicaid results achieved by RMHP during the current year (FY 2007–2008) and the prior year (FY 2006–2007).

Table 3-21—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	58.1%	61.3%
Getting Care Quickly	58.6%	63.4%
How Well Doctors Communicate	67.1%	69.7%
*Customer Service**	*	66.3%
Shared Decision Making	57.4%	59.3%
Rating of Personal Doctor	66.8%	68.4%
Rating of Specialist Seen Most Often	61.2%	68.4%
Rating of All Health Care	50.6%	54.8%
Rating of Health Plan	56.9%	63.5%

* Due to changes in the *Customer Service* composite, the results for this measure are not comparable across the two years reported in the table, per NCQA.

Recommendations

RMHP had no measures with decreasing rates and should continue to monitor patient satisfaction levels and assess the effects of quality improvement activities on overall satisfaction.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

Due to terms stipulated by the Department, FY 2007–2008 child Medicaid results were not reported for RMHP. Therefore, HSAG could not perform a year-to-year comparison for RMHP or provide recommendations for the child Medicaid population.

For the adult Medicaid population, all eight of RMHP's comparable measures' rates increased. Two of the measures' rates increased by more than 5 percentage points: *Rating of Specialist Seen Most Often* (7.2 percentage points) and *Rating of Health Plan* (6.6 percentage points). Furthermore, RMHP had the highest rates among the health plans for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

Primary Care Physician Program

Findings

Table 3-22 displays the child Medicaid results achieved by PCPP during the current year (FY 2007–2008) and the prior year (FY 2006–2007).

Table 3-22—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	80.7%	78.0%
Getting Care Quickly	53.7%	56.4%
How Well Doctors Communicate	65.6%	68.4%
Courteous and Helpful Office Staff	69.9%	70.7%
Customer Service	NA	NA
Rating of Personal Doctor	60.4%	66.4%
Rating of Specialist Seen Most Often	65.8%	65.2%
Rating of All Health Care	64.1%	67.8%
Rating of Health Plan	61.1%	63.0%
NA indicates that a rate was not assigned due to there being fewer than 100 respondents.		

Table 3-23 displays the adult Medicaid results achieved by PCPP during the current year (FY 2007–2008) and the prior year (FY 2006–2007).

Table 3-23—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2006–2007 Rate	FY 2007–2008 Rate
Getting Needed Care	57.3%	49.9%
Getting Care Quickly	59.9%	55.8%
How Well Doctors Communicate	67.3%	62.5%
*Customer Service**	*	NA
Shared Decision Making	62.0%	61.1%
Rating of Personal Doctor	65.1%	60.9%
Rating of Specialist Seen Most Often	64.9%	62.0%
Rating of All Health Care	51.2%	46.1%
Rating of Health Plan	50.4%	48.2%
NA indicates that a rate was not assigned due to there being fewer than 100 respondents. * Due to changes in the *Customer Service* composite, the results for this measure are not comparable across the two years reported in the table, per NCQA.		

Recommendations

Although the child Medicaid survey rates did not show substantial decreases, PCPP should continue to direct quality improvement activities toward those measures that had a reduction. Recommendations for improving performance for *Getting Needed Care* include scheduling models that allow for appointment flexibility, simplified patient flow that limits bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education. Quality improvement activities targeting *Rating of Specialist Seen Most Often* include increasing specialist availability and streamlining the referral process to allow patients to receive prompt and appropriate care.

The adult Medicaid survey results showed substantial decreases for two measures: *Getting Needed Care* and *Rating of All Health Care*. Therefore, PCPP should continue to direct quality improvement activities toward these measures. Recommendations for improving performance include:

- ***Getting Needed Care*—**Having scheduling models that allow for appointment flexibility, simplified patient flow, increased electronic communications that may reduce the need for an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***Rating of All Health Care*—**Increasing access to care and improving overall patient satisfaction with patient health care and health plan experiences.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

For the child Medicaid population, six of the comparable measures' rates increased. One of the measure's rates increased by more than 5 percentage points: *Rating of Personal Doctor* (6.0 percentage points). Two of the measures' rates decreased from FY 2006–2007 to FY 2007–2008: *Getting Needed Care* and *Rating of Specialist Seen Most Often*; however, neither of these reductions in rates was substantial.

For the adult Medicaid population, all eight of the comparable measures' rates decreased. Two of those measures decreased by more than 5 percentage points: *Getting Needed Care* (7.4 percentage points) and *Rating of All Health Care* (5.1 percentage points). Furthermore, PCPP had the lowest rates among all the health plans for *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*. PCPP did, however, have the highest rate among all the health plans for the *Shared Decision Making* measure.

Overall Statewide Performance for Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table 3-24 displays the child Medicaid statewide averages for the prior year (FY 2006–2007).

Table 3-24—Child Medicaid Statewide Averages		
Measure	**FY 2006–2007 Rate**	**FY 2007–2008**
Getting Needed Care	83.3%	†
Getting Care Quickly	51.2%	†
How Well Doctors Communicate	67.6%	†
Courteous and Helpful Office Staff	68.0%	†
Customer Service	NA	†
Rating of Personal Doctor	65.6%	†
Rating of Specialist Seen Most Often	65.8%	†
Rating of All Health Care	64.1%	†
Rating of Health Plan	62.3%	†

† Since rates for DHMC and RMHP were not reportable for FY 2007–2008, a child Medicaid statewide average could not be calculated.

NA indicates that none of the plans met the threshold of 100 responses required to report a measure.

Due to terms stipulated by the Department, FY 2007–2008 child Medicaid results were not reported for DHMC and RMHP. Therefore, a statewide average year-to-year comparison could not be performed and recommendations for the child Medicaid population could not be provided.

Table 3-25 displays the adult Medicaid statewide averages during the current year (FY 2007–2008) and the prior year (FY 2006–2007).

Table 3-25—Adult Medicaid Statewide Averages		
Measure	**FY 2006–2007 Rate**	**FY 2007–2008**
Getting Needed Care	53.3%	52.0%
Getting Care Quickly	55.9%	55.8%
How Well Doctors Communicate	68.9%	68.7%
Customer Service	*	**
Shared Decision Making	57.5%	59.8%
Rating of Personal Doctor	67.1%	67.0%
Rating of Specialist Seen Most Often	60.8%	63.5%
Rating of All Health Care	49.3%	51.0%
Rating of Health Plan	52.9%	56.0%

* Due to changes in the *Customer Service* composite, the results for this measure are not comparable across the two years reported in the table, per NCQA.

** Only one health plan was able to report the *Customer Service* measure; therefore, a state average was not calculated.

Recommendations

Recommendations for improvement were made for each health plan based on their performance on the measures and included:

- ***Getting Needed Care***—Having flexible scheduling, simplified patient flow, increased electronic communications that may reduce the need for an appointment, and improved access to health care information via the Internet.
- ***Getting Care Quickly***—Having scheduling models that allow for appointment flexibility, simplified patient flow that limits bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***How Well Doctors Communicate***—Having skills training for clinicians through seminars and workshops; communication tools for patients, including structured question lists and copies of their medical records; educational literature for patients; management of patient visits by ensuring that they have necessary tests completed before an appointment and that they understand all the information provided to them; and a system that sends out routine and preventive care reminders to patients.
- ***Rating of Personal Doctor***—Having increased levels of patient-physician communication and decreased wait times by eliminating barriers that may prohibit patients from receiving prompt, adequate care.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness

For the statewide adult Medicaid population, four of the comparable measures' rates increased: *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. However, none of the increases were substantial (i.e., none of the rates increased by more than 5 percentage points).

The statewide adult Medicaid survey results decreased for four of the measures. However, none of these decreases was substantial (i.e., none of the rates decreased by more than 5 percentage points). Nonetheless, the State should continue to direct quality improvement activities toward those measures that had a decline in performance: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*.

Focused Studies

HSAG conducted two focused studies of health care for the Department. The topics of these studies were coordination of care between physical and behavioral health care providers for members diagnosed with a serious mental illness (SMI) and adolescent well care. The adolescent well-care focused study was a remeasurement of a baseline study conducted by HSAG in FY 2005–2006. The methodology was the same as the methodology of the FY 2005–2006 study.

The coordination of care focused study is new and will serve as a baseline study.

When appropriate, this section includes comparisons to the original FY 2005–2006 Colorado Medicaid Adolescent Well-Care baseline study. However, due to population changes in the distribution of members across health plans, caution should be used when interpreting differences in performance between study years. Each focused study report includes a more comprehensive list of limitations.

Appendix E contains detailed information about the methods of data collection and analysis for each study.

Coordination of Care

Colorado Medicaid behavioral health services are "carved out" and provided through BHOs. The inherent structure of carve-outs coupled with special protections established in Colorado statute for individuals with an SMI contribute to barriers in coordinating care between the medical and behavioral health delivery systems. The Department has made increased coordination of care between behavioral health and physical health care providers a high priority and has initiated activities within both systems to explore ways to improve coordination.

The Department hosted a discussion between MQuIC and the Behavioral Quality Improvement Committee in August 2007. The meeting resulted in a plan to immediately begin addressing coordination issues. The Department arranged for an educational presentation at the February 2008 MQuIC meeting, where representatives from BHOs provided information on referrals and provided directories of key contacts to health plans. A Department BHO contracts manager and the executive director of the Colorado Behavioral Healthcare Council also participated in this forum to explore care coordination solutions. This collaboration resulted in the decision to conduct a utilization study to identify where and how frequently members with an SMI access medical care. The study is a first step toward understanding this vulnerable population's use of services to pinpoint key areas for communication improvement.

FY 2007–2008 Phase I: Coordination of Care Utilization of Services for Members Diagnosed With a Serious Mental Illness Focused Study is part of a Colorado statewide initiative to improve communication between the two delivery systems—physical health care providers and the behavioral health organizations—treating Medicaid-eligible individuals diagnosed with an SMI. The goal of the study was to provide information on utilization of medical services by these

members and address the following question: When members with an SMI access medical care, where and how frequently do they access this care and what are the three most common diagnoses?

Measures evaluated and reported in the study were:

- Measure 1— *Members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider*
- Measure 2— *Members with an SMI diagnosis who had at least one emergency room visit during the measurement period*
- Measure 3a—*Members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period*
- Measure 3b—*Members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period*
- Measure 4—*Utilization of services for members with an SMI diagnosis*

Adolescent Well Care

The Adolescent Well-Care Focused Study was a quantitative study based on national HEDIS technical specifications. The HEDIS adolescent well-care measure was based on the percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist during the measurement year. Administrative claims data were analyzed for the measurement period of January 1, 2007, through December 31, 2007. Measures evaluated and reported in the baseline and remeasurement studies included three quantifiable and two calculated measures as follows:

- Measure 1—*Adolescent well-care visits* (HEDIS methodology)
- Measure 2—*Adolescents with no services*
- Measure 3—*Adolescents with a physician office visit but no well-care visit*
- Measure 4—*Adolescents with services but no physician office visit or well-care visit*
- Measure 5—*Potential and missed opportunity*

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the health plans using findings from the focused studies, HSAG assigned each of the measures to one or more of the three domains displayed in Table E-1 in Appendix E.

Denver Health Medicaid Choice

Findings

Table 3-26 displays rates obtained by DHMC for each measure of each focused study. The adolescent well-care study includes both baseline study (FY 2005–2006) and remeasurement (FY 2007–2008) rates.

Table 3-26—Focused Study Rates *for* DHMC

Focused Study Measures	FY 2005–2006 Rate	FY 2007–2008 Rate
Coordination of Care		
Members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	71.2%
Members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	19.2%
Members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	6.1%
Members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	8.4%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	27.8%	31.9%
Adolescents with no services	27.3%	22.3%
Adolescents with a physician office visit but no well-care visit	40.2%	36.6%
Adolescents with services but no physician office visit or well- care visit	4.7%	9.2%
Potential and missed opportunity	72.2%	68.1%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

Table 3-27 displays the number of DHMC members with an SMI diagnosis, the number of visits, average visits per member, and the three diagnoses that occurred most frequently by health care delivery setting.

Table 3-27—DHMC Visits per Member and Top Three Diagnoses for Individuals With an SMI					
				Inpatient Admission	
		Preventive/ Ambulatory Visit	Emergency Room (ER) Visit	Physical Health Hospital	Mental Health Hospital[A]
Total number of SMI members		1,095	1,095	1,095	1,095
Total number of visits		5,484	423	162	92
Average visits per member		5.01	0.39	0.15	0.08
Top Three Diagnoses[B]					
Diagnosis 1	**Description**	*Special investigations and examinations* (V72)	*General symptoms* (780) *Symptoms involving respiratory system and other chest symptoms* (786)	*General symptoms* (780)	*Schizophrenic disorders* (295)
	N	350	39	15	56
	%	6.4%	9.2%	9.3%	60.9%
Diagnosis 2	**Description**	*Diabetes mellitus* (250)	*Other symptoms involving abdomen and pelvis* (789)	*Other diseases of lung* (518)	*Episodic mood disorders* (296)
	N	287	18	9	28
	%	5.2%	4.3%	5.6%	30.4%
Diagnosis 3	**Description**	*Essential hypertension* (401)	*Asthma* (493) *Other and unspecified disorders of back* (724)	*Other cellulitis and abscess* (682) *Symptoms involving respiratory system and other chest symptoms* (786)	*Drug-induced mental disorders* (292) *Other nonorganic psychoses* (298) *Depressive disorder, not elsewhere classified* (311)
	N	179	15	8	2
	%	3.3%	3.5%	4.9%	2.2%

[A] Only the member's first admission in the measurement period was tracked for mental health inpatient admissions.
[B] Diagnosis codes from the primary fields were assessed based on the first three digits of the ICD-9-CM codes.

Assessment and Recommendations

Coordination of Care

All coordination of care focused study measures were access measures.

Among the health plans, DHMC had the lowest rate (19.2 percent) of members diagnosed with an SMI who had one or more emergency room visits. In addition, DHMC had the lowest rate (6.1 percent) of members diagnosed with an SMI who had at least one inpatient admission to a physical health hospital during FY 2006–2007. In addition, DHMC had the lowest utilization for the emergency room and physical health inpatient settings with 0.39 and 0.15 average visits per member, respectively. For mental health inpatient admissions, DHMC's rate was nearly four times higher than the rate of the other health plans.

For preventive/ambulatory visits and physical health inpatient admissions, DHMC reported the most frequently occurring diagnosis as *special investigations and examinations* (V72) and *general symptoms* (780), respectively. The other health plans did not report these diagnoses among their top three most frequently occurring diagnoses.

DHMC reported *asthma* as one of the top three most frequently occurring diagnoses. This finding may indicate the need to explore care management programs for effectiveness in preventing emergency room visits because asthma is a controllable condition.

Based on the results of this year's coordination of care focused study findings, HSAG recommended the following:

- Codes V72 (*special investigations and examinations*) and 780 (*general symptoms*) may warrant further investigation to determine if there may be provider/billing issues. For the health care settings analyzed in this study, more specific primary diagnoses were anticipated.
- DHMC could further investigate the detailed utilization of those members diagnosed with an SMI as identified by the Department.

Adolescent Well-Care

All adolescent well-care focused study measures were access measures.

The DHMC rate for *Adolescent well-care visits*, which calculated the percentage of members who had a well-care visit, was 31.9 percent, which was 10.2 percentage points below the NCQA HEDIS 2007 national Medicaid 50th percentile rate of 42.1 percent. DHMC's rate for this measure was the second highest among the health plans and increased 4.1 percentage points from the FY 2005–2006 rate.

Among the health plans DHMC had the lowest rate (36.6 percent) for *Adolescents with a physician office visit but no well-care visit* (Measure 3), which was 3.6 percentage points lower than the FY 2005–2006 study result. In addition, DHMC was the only plan that decreased its rate for Measure 3 from FY 2005–2006 to FY 2007–2008. This finding is important because Measure 3 represents the

greatest opportunity to improve the rate of well-care visits since the physician is already evaluating the member during an office visit.

Based on the results of this year's adolescent well-care focused study findings, HSAG recommends the following:

- The health plan should focus on ongoing communication designed to provide practitioners and their office staff with best practices that could help increase well-child visit rates. Providers should be directed to the Department's EPSDT toolkit to find a sample reminder letter that they can mail to parents and guardians, notifying them that their child is overdue for an exam.
- The health plan should conduct ongoing reviews of utilization for members younger than 21 years of age to identify those who are eligible for well-care visits. The health plan could generate quarterly reports for providers that highlight adolescents in need of well-care visits, which providers could use to promote visit reminders. In addition, the health plan could use member profile reports as part of a provider incentive program to reduce the rate of missed opportunities.

Rocky Mountain Health Plans

Findings

Table 3-28 displays rates obtained by RMHP for each measure of each focused study. The adolescent well-care study includes both baseline study (FY 2005–2006) and remeasurement (FY 2007–2008) rates.

Table 3-28—Focused Study Rates *for* RMHP

Focused Study Measures	FY 2005–2006 Rate	FY 2007–2008 Rate
Coordination of Care		
Members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	88.3%
Members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	45.6%
Members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	17.4%
Members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	2.0%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	35.7%	40.8%
Adolescents with no services	8.9%	0.6%
Adolescents with a physician office visit but no well-care visit	51.2%	56.6%
Adolescents with services but no physician office visit or well-care visit	4.2%	2.0%
Potential and missed opportunity	64.3%	59.2%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

Table 3-29 displays the number of RMHP members with an SMI diagnosis, the number of visits, average visits per member, and the three diagnoses that occurred most frequently by health care delivery setting.

Table 3-29—RMHP Visits per Member and Top Three Diagnoses for Individuals With an SMI					
				Inpatient Admission	
		Preventive/ Ambulatory Visit	Emergency Room (ER) Visit	Physical Health Hospital	Mental Health Hospital[A]
Total number of SMI members		454	454	454	454
Total number of visits		3,101	735	107	9
Average visits per member		6.83	1.62	0.24	0.02
Top Three Diagnoses[B]					
Diagnosis 1	**Description**	*Diabetes mellitus* (250)	*Symptoms involving head and neck* (784)	*Symptoms involving respiratory system and other chest symptoms* (786)	*Schizophrenic disorders* (295)
	N	213	72	6	5
	%	6.9%	9.8%	5.6%	55.6%
Diagnosis 2	**Description**	*General symptoms* (780)	*Other symptoms involving abdomen and pelvis* (789)	*Other symptoms involving abdomen and pelvis* (789)	*Adjustment reaction* (309)
	N	149	65	5	2
	%	4.8%	8.8%	4.7%	22.2%
Diagnosis 3	**Description**	*Other and unspecified disorders of back* (724)	*Symptoms involving respiratory system and other chest symptoms* (786)	*Disorders of fluid, electrolyte, and acid-base balance* (276) *Pneumonia, organism unspecified* (486) *Disorders of menstruation and other abnormal bleeding from female genital tract* (626)	*Episodic mood disorders* (296) *Anxiety, dissociative and somatoform disorders* (300)
	N	141	44	4	1
	%	4.5%	6.0%	3.7%	11.1%

[A] Only the member's first admission in the measurement period was tracked for mental health inpatient admissions.
[B] Diagnosis codes from the primary fields were assessed based on the first three digits of the ICD-9-CM codes.

Assessment and Recommendations

Coordination of Care

All coordination of care focused study measures were access measures.

At 88.3 percent, RMHP had the highest rate of members diagnosed with a SMI that had at least one preventive/ambulatory visit during FY 2006–2007. In addition, RMHP had the lowest rate among the health plans of members diagnosed with an SMI who had one or more mental health inpatient admission at 2.0 percent.

However, the rate of emergency room visits and the rate of physical health inpatient admissions were the highest among the health plans at 45.6 percent and 17.4 percent, respectively. RMHP had the highest average visits per member for preventive/ambulatory, emergency room, and physical health inpatient settings with 6.83, 1.62, and 0.24 average visits per member, respectively. This finding contradicts expectations that higher preventive/ambulatory utilization would decrease emergency room and physical health inpatient admissions.

RMHP reported *General symptoms* (780) as the second most frequently occurring diagnosis for preventive/ambulatory visits—a diagnosis that was not reported by the other health plans.

Based on the results of this year's coordination of care focused study findings, HSAG recommends the following:

- Codes 780 (*general symptoms*) may warrant further investigation. Furthermore, RMHP should investigate any visits with a primary diagnosis that includes *general symptoms* in the description. For the health care settings analyzed in this study, more specific primary diagnoses were anticipated.
- To facilitate coordination of care between behavioral health and physical health providers, the Department may consider providing each health plan with a list of its members diagnosed with an SMI on a predetermined time interval. This would allow health plans to identify health care needs for their members diagnosed with an SMI. In addition, the Department may consider having quarterly regional meetings between the health plans and behavioral health organizations.
- RMHP could further investigate the detailed utilization of those members diagnosed with an SMI as identified by the Department.

Adolescent Well Care

All adolescent well-care focused study measures were access measures.

Four out of 10 adolescents at RMHP had a well-care visit, which was slightly below the NCQA HEDIS 2007 national Medicaid 50th percentile of 42.1 percent. Moreover, from FY 2005–2006 to FY 2007–2008, RMHP increased the rate for *adolescent well-care visits* by 5.1 percent, the largest increase among the health plans.

In addition, RMHP had the lowest rate of adolescents without any administrative claims or encounters at 0.6 percent, which was a decrease of 8.3 percentage points from the FY 2005–2006 study. This finding suggests that more adolescents were utilizing health care services in FY 2007–2008 compared to FY 2005–2006.

Based on the results of this year's adolescent well-care focused study findings, HSAG recommends the following:

- Health plans should conduct ongoing reviews of utilization for members younger than 21 years of age to identify those who are eligible for well-care visits. Health plans could generate quarterly reports that highlight adolescents in need of well-care visits, which providers could use to promote visit reminders. In addition, health plans could use member profile reports as part of a provider incentive program to reduce the rate of missed opportunities.
- The health plans should educate providers and their front office personnel about reviewing the health records of all family members younger than 21 years of age before any of the family members' scheduled appointments. This step would allow the physician to remind parents of the need for well-care visits. Provider office staff should remind parents at the end of every well-care visit of the importance of returning for subsequent well-care visits.

Primary Care Physician Program

Findings

Table 3-30 displays rates obtained by PCPP for each measure of each focused study. The adolescent well-care study includes both baseline study (FY 2005–2006) and remeasurement (FY 2007–2008) rates.

Table 3-30—Focused Study Rates *for* PCPP

Focused Study Measures	FY 2005–2006 Rate	FY 2007–2008 Rate
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	60.2%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	27.3%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	11.0%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	3.3%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	12.4%	14.9%
Adolescents with no services	7.5%	5.3%
Adolescents with a physician office visit but no well-care visit	56.7%	58.8%
Adolescents with services but no physician office visit or well-care visit	23.4%	21.0%
Potential and missed opportunity	87.6%	85.1%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

Table 3-31 displays the number of PCPP members with an SMI diagnosis, the number of visits, average visits per member, and the three diagnoses that occurred most frequently by health care delivery setting.

Table 3-31—PCPP Visits per Member and Top Three Diagnoses for Individuals With an SMI					
				Inpatient Admission	
		Preventive/ Ambulatory Visit	Emergency Room (ER) Visit	Physical Health Hospital	Mental Health Hospital[A]
Total number of SMI members		1,504	1,504	1,504	1,504
Total number of visits		7,121	1,074	241	49
Average visits per member		4.73	0.71	0.16	0.03
Top Three Diagnoses[B]					
Diagnosis 1	**Description**	*Diabetes mellitus* (250)	*General symptoms* (780)	*Pneumonia, organism unspecified* (486)	*Schizophrenic disorders* (295)
	N	463	77	12	25
	%	6.5%	7.1%	5.0%	51.0%
Diagnosis 2	**Description**	*Essential hypertension* (401)	*Symptoms involving respiratory system and other chest symptoms* (786)	*Disorders of fluid, electrolyte, and acid-base balance* (276) *General symptoms* (780)	*Episodic mood disorders* (296)
	N	354	71	9	19
	%	5.0%	6.6%	3.7%	38.8%
Diagnosis 3	**Description**	*Other and unspecified disorders of back* (724)	*Other symptoms involving abdomen and pelvis* (789)	*Asthma* (493) *Intestinal obstruction without mention of hernia* (560)	*Depressive disorder, not elsewhere classified* (311)
	N	308	68	8	2
	%	4.3%	6.3%	3.3%	4.1%

[A] Only the member's first admission in the measurement period was tracked for mental health inpatient admissions.
[B] Diagnosis codes from the primary fields were assessed based on the first three digits of the ICD-9-CM codes.

Assessment and Recommendations

Coordination of Care

All coordination of care focused study measures were access measures.

Among the health plans, PCPP had the lowest rate of members diagnosed with an SMI who had one or more preventive/ambulatory visits during FY 2006–2007 at 60.2 percent. For the remaining measures, the PCPP results were neither the lowest nor the highest, but were between the other two health plans' results.

For members diagnosed with an SMI, PCPP had the lowest average visits per member for the preventive/ambulatory setting at 4.73. The PCPP average visits per member for both mental and physical health inpatient admissions were very close to the lowest rate among the health plans, separated by 1 visit per 100 members.

This finding contradicts expectations that lower average visits per member for preventive/ambulatory visits would lead to higher emergency room and inpatient admissions. This was not the case, with both the mental and physical health inpatient admissions being nearly the lowest among the health plans.

PCPP reported *asthma (493)* as one of the top three most frequently occurring diagnoses for physical health inpatient admissions. This finding may indicate the need to explore care management programs for effectiveness in preventing physical health inpatient admissions because asthma is a controllable condition.

Based on the results of this year's coordination of care focused study findings, HSAG recommends the following:

- PCPP reported *Asthma (493)* as one of the top three most frequently occurring diagnoses for physical health inpatient admissions. HSAG recommends that PCPP further investigate why these members had inpatient admissions.
- PCPP should further investigate utilization results for those members diagnosed with an SMI, as identified by the Department.
- *General symptoms (780)* may warrant further investigation to determine if there may be provider/billing issues among the health plans. Furthermore, PCPP could investigate any visits with a primary diagnosis that includes *general symptoms* in the description. For the health care settings analyzed in this study, more specific primary diagnoses were anticipated.

Adolescent Well Care

All of the adolescent well-care focused study measures were access measures.

PCPP had the lowest rate of adolescents with one or more well-care visits among the health plans during FY 2007–2008 at 14.9 percent, which was 27.2 percentage points below the 2007 NCQA national HEDIS Medicaid 50th percentile. However, the rate for *adolescent well-care visits* increased 2.5 percentage points above the FY 2005–2006 rate.

PCPP had the highest rate of *adolescents with a physician office visit but no well-care visit* at 58.8 percent. This measure represents the greatest opportunity for increasing well-care visits. In addition, PCPP had a rate of *adolescents with services but no physician office visit or well-care visit* that was 2 to 10 times greater than the other health plans, meaning that adolescents are accessing care but are not receiving well-care visits. These findings indicate that PCPP has the greatest opportunity to improve adolescent well-care visits among the health plans.

Based on the results of this year's adolescent well-care focused study findings, HSAG recommends the following for PCPP to improve its performance:

- The Department should focus on ongoing communication designed to provide practitioners and their office staff with best practices that could help increase well-child visit rates. Providers should be directed to the Department's EPSDT toolkit to find a sample reminder letter that can be mailed to parents and guardians, notifying them that their child is overdue for an exam. This letter reminds parents of the importance of well-care appointments and explains what they can expect during a well-care appointment.
- The Department may use materials from the National Center for Education in Maternal and Child Health, at www.brightfutures.org. It has resources that providers could use to help facilitate well-child visits. Standardized tracking forms could be modified and used to help providers track adolescent well-care visits.

Overall Statewide Performance for the Focused Studies

Table 3-32 displays the statewide average rates for each focused study. The table lists rates for both the remeasurement (FY 2007–2008) and baseline study (FY 2005–2006).

Table 3-32—Focused Study Rates *for* Statewide Average Rates

Focused Study Measures	FY 2005–2006 Rate[1]	FY 2007–2008 Rate[2]
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	68.4%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	27.1%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	10.2%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	4.9%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	22.4%	25.3%
Adolescents with no services	11.7%	10.8%
Adolescents with a physician office visit but no well-care visit	49.3%	50.3%
Adolescents with services but no physician office visit or well-care visit	16.7%	13.6%
Potential and missed opportunity	77.6%	74.7%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

[1] The aggregate rate for Colorado Access, DHMC, RMHP, and PCPP.
[2] The aggregate rate for DHMC, RMHP, and PCPP.

Table 3-33 displays the number of members statewide with an SMI diagnosis, the number of visits, average visits per member, and the three diagnoses that occurred most frequently by health care delivery setting.

Table 3-33—Statewide Visits per Member and Top Three Diagnoses for Individuals With an SMI					
				Inpatient Admission	
		Preventive/ Ambulatory Visit	Emergency Room (ER) Visit	Physical Health Hospital	Mental Health Hospital[A]
Total number of SMI members		3,053	3,053	3,053	3,053
Total number of visits		15,706	2,232	510	150
Average visits per member		5.14	0.73	0.17	0.05
Top Three Diagnoses[B]					
Diagnosis 1	**Description**	*Diabetes mellitus* (250)	*Symptoms involving respiratory system and other chest symptoms* (786)	*General symptoms* (780)	*Schizophrenic disorders* (295)
	N	963	154	26	86
	%	6.1%	6.9%	5.1%	57.3%
Diagnosis 2	**Description**	*Essential hypertension* (401)	*Other symptoms involving abdomen and pelvis* (789)	*Other diseases of lung* (518)	*Episodic mood disorders* (296)
	N	672	151	19	48
	%	4.3%	6.8%	3.7%	32.0%
Diagnosis 3	**Description**	*Other and unspecified disorders of back* (724)	*General symptoms* (780)	*Disorders of fluid, electrolyte, and acid-base balance* (276) *Symptoms involving respiratory system and other chest symptoms* (786)	*Adjustment reaction* (309) *Depressive disorder, not elsewhere classified* (311)
	N	597	144	18	4
	%	3.8%	6.4%	3.5%	2.7%

[A] Only the member's first admission in the measurement period was tracked for mental health inpatient admissions.
[B] Diagnosis codes from the primary fields were assessed based on the first three digits of the ICD-9-CM codes.

Assessment and Recommendations

Coordination of Care

All of the coordination of care focused study measures were access measures.

Almost 7 out of 10 members diagnosed with an SMI had a preventive/ambulatory visit during FY 2006–2007. In addition, these members had a lower percentage of physical and mental health inpatient admissions at 10.2 and 4.9, respectively, compared to emergency room admissions at 27.1 percent. Conversely, nearly 3 out of 10 members diagnosed with an SMI had at least one emergency room visit during FY 2006–2007.

Statewide, members diagnosed with an SMI had about five visits per member (5.14) in the preventive/ambulatory setting. Members diagnosed with an SMI are accessing preventive/ambulatory services for physical health care at an average of about 7 to 105 times more often than the other health care delivery settings (emergency room, physical health inpatient admission, mental health inpatient admission). In fact, the total number of preventive/ambulatory visits was five times greater than all other settings combined.

The three diagnoses that occurred most frequently for members in the preventive/ambulatory setting were *diabetes mellitus (250), essential hypertension (401,* and *other and unspecified disorders of back (724).*

For the emergency room setting, the three diagnoses that occurred most frequently were *symptoms involving respiratory system and other chest symptoms (786), other symptoms involving abdomen and pelvis (789),* and *general symptoms (780).* Code 780 (*general symptoms*) could be investigated to determine how a nonspecific ICD-9-CM code was entered as the primary diagnosis for an emergency room visit.

The three diagnosis that occurred most frequently for physical health inpatient admissions were *general symptoms (780), other diseases of the lung (518),* and *symptoms involving respiratory system and other chest symptoms* and *disorders of fluid, electrolyte, and acid-base balance* (tied for third place).

Several diagnoses were used to define the SMI population. It was clear that SMI members diagnosed with *schizophrenic disorders* and *episodic mood disorders* were more likely to have a mental health inpatient admission. For members diagnosed with an SMI, 89.3 percent of the mental health inpatient admissions analyzed had either *schizophrenic disorders* (57.3 percent) or *episodic mood disorders* (32.0 percent) as the primary diagnosis.

The Department has made increased coordination of care between behavioral health and physical health care providers a high priority and has initiated activities within both systems to explore ways to improve coordination. Based on the results of this year's coordination of care focused study findings, HSAG recommends the following to improve statewide performance:

- To facilitate coordination of care between behavioral health and physical health providers, the Department may consider providing each health plan with a list of its members diagnosed with

an SMI on a predetermined time interval. This would allow health plans to identify the health care needs of their members diagnosed with an SMI. In addition, the Department may consider having quarterly regional meetings between the health plans and behavioral health organizations.

- Code 780 (*general symptoms*) may warrant further investigation to determine if there may be provider/billing issues among the health plans. Furthermore, any visits with a primary diagnosis that includes *general symptoms* in the description could also be investigated. For the health care settings analyzed, more specific primary diagnoses were anticipated.
- Based on the data from this baseline study, it is not possible to make any firm conclusions regarding utilization patterns. For the measures evaluated in this study, utilization results could be further investigated for those members diagnosed with an SMI, as identified by the Department.

Adolescent Well Care

All of the adolescent well-care focused study measures were access measures.

The rate of *adolescent well-care visits* increased 2.9 percentage points from FY 2005–2006 and was 16.8 percentage points below the NCQA HEDIS 2007 national Medicaid 50th percentile of 42.1 percent. The percentage of *adolescents with services but no physician office visit or well-care visit* decreased 3.1 percentage points from FY 2005–2006 to FY 2007-2008. This change indicated that more adolescents were having well-care visits and physician office visits.

The opportunity to perform a well-care visit during a physician office visit increased 17.2 percentage points from FY 2005–2006. This finding suggests the greatest opportunity to increase well-care visits.

Based on the results of this year's adolescent well-care focused study findings, HSAG recommends the following to improve statewide performance:

- The health plans should focus on ongoing communication designed to provide practitioners and their office staff with best practices that could help increase well-child visit rates. Providers should be directed to the Department's EPSDT toolkit to find a sample reminder letter that providers can mail to parents and guardians, notifying them that their child is overdue for an exam. This letter reminds parents of the importance of well-care appointments and explains what they can expect during a well-care appointment.
- Health plans should conduct ongoing reviews of utilization for members younger than 21 years of age to identify those who are eligible for well-care visits. Health plans could generate quarterly reports for providers that highlight adolescents in need of well-care visits, which providers could use to promote visit reminders. In addition, the health plans could use member profile reports as part of a provider incentive program to reduce the rate of missed opportunities.

4. Assessment of Health Plan Follow-up on Prior Recommendations

Introduction

This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations made by the Department and HSAG during the previous year. As noted in Section 3 of this report, the Department revised its compliance monitoring process and point-to-point comparisons of the prior year's recommendations may not be possible for all elements.

Denver Health Medicaid Choice

Compliance Monitoring Site Reviews—In the Department's August 2007 Final Site Review Findings report, DHMC received a total score of 89 percent in the compliance monitoring evaluation. There were 24 corrective actions required as a result of the review related to: (1) audits and reporting, (2) claims processing, (3) confidentiality, (4) member facilitation and accommodation, and (5) member rights and responsibilities. In December 2007, the Department accepted 23 of DHMC's corrective action plans, 2 of which were accepted with additional requirements specified by the Department. The 2008 site review findings documented that DHMC had completed 33 percent of the corrective actions from the 2007 site review. Corrective actions were continued for 20 of the original 24 recommendations.

Validation of Performance Measures—In FY 2006–2007, DHMC had one measure that fell below the national HEDIS Medicaid 10th percentile: *Postpartum Care.* HSAG recommended that DHMC implement quality strategies to improving rates for this measure. Although the rate has increased from 33.91 percent to 55.23 percent in FY 2007–2008, due to the changes in the HEDIS 2008 specifications, HSAG could not ascertain whether the increased rate was evidence of performance improvement. Nonetheless, this measure has improved from being below the national HEDIS Medicaid 10th percentile to being within the 25–50th percentile. The health plan stated that it had conducted educational efforts with practitioners to schedule postpartum visits 21–56 days after delivery.

Validation of PIPs—The FY 2006–2007 PIP validation did not identify any opportunities for improvement for either PIP. HSAG had no recommendations.

Focused Studies—HSAG made several recommendations to improve rates measured in both the FY 2006–2007 Perinatal Care Focused Study and the FY 2006–2007 Asthma Medication Management Focused Study. However, it is too soon to remeasure for any significant improvements.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews—In the Department's July 2007 Final Site Review Findings report, RMHP received a total score of 97 percent in the compliance monitoring evaluation. There were seven corrective actions required as a result of the review related to: (1) audits and reporting, (2) claims processing, (3) confidentiality, (4) member facilitation and accommodation, and (5) member rights and responsibilities. In November 2007, the Department accepted the corrective action plan proposed by RMHP, with additional requirements specified to provide prevention and education outreach to specific cultural and ethnic groups. The 2008 site review findings documented that RMHP had completed 71 percent of corrective actions from the 2007 site review. RMHP had completed five of the seven corrective actions, and two corrective actions were partially complete (regarding advance directives and staff training on cultural competency).

Validation of Performance Measures—In FY 2006–2007, RMHP had several measures—*Adolescent Well-Care Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Comprehensive Diabetes Care—Poor HbA1c Control* and *Eye Exam*—for which HSAG recommended focusing improvement efforts. Because RMHP did not report on the *Comprehensive Diabetes Care* measure for the FY 2007–2008 measurement cycle, HSAG could not ascertain any evidence of improvement on this measure. The rate for *Adolescent Well-Care Visits* improved by only 1.36 percentage points, and the rate for the *Well-Child Visits 3-6 Years of Life* declined from 67.09 percent in FY 2006–2007 to 59.55 percent in the current measurement cycle.

Validation of PIPs—The FY 2006–2007 PIP validation did not identify any opportunities for improvement for either PIP. HSAG had no recommendations.

Focused Studies—HSAG made several recommendations to improve rates measured in both the FY 2006–2007 Perinatal Care Focused Study and the FY 2006–2007 Asthma Medication Management Focused Study. However, it is too soon to remeasure for any significant improvements.

Primary Care Physician Program

Compliance Monitoring Site Reviews—As a primary care case management program run by Colorado Medicaid, PCPP was not subject to compliance monitoring reviews.

Validation of Performance Measures—HSAG recommended in FY 2006–2007 that PCPP increase improvement efforts on the *Comprehensive Diabetes Care—HbA1c Testing, Poor HbA1c Control,* and *Eye Exam* measures and the *Childhood Immunization Status—Combo #*2 and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. Because the *Comprehensive Diabetes Care* measure was not reported for the FY 2007–2008 measurement cycle, HSAG could not ascertain any evidence of improvement on this measure. Since the increase in performance for *Childhood Immunization Status—Combo #2* may be related to specification changes, evidence of improvement put forth by PCPP could not be confirmed. Nonetheless, since the rate increased almost 30 percentage points, with the corresponding percentile ranking changing from the <10th percentile to the 50–75th percentile, it is conceivable that PCPP may have focused

its improvement efforts on this measure. Lastly, PCPP's efforts in improving the *Well-Child Visits 3–6 Years of Life* measure were evident in the measure's significant rate increase (21.46 percentage points) during the current measurement cycle.

Validation of PIPs—As a primary care case management program run by Colorado Medicaid, PCPP was not required to conduct PIPs.

Focused Studies—HSAG made several recommendations to improve rates measured in both the FY 2006–2007 Perinatal Care Focused Study and the FY 2006–2007 Asthma Medication Management Focused Study. However, it is too soon to remeasure for any significant improvements.

Appendix A. EQR Activities—Compliance Monitoring Site Reviews

Introduction

This appendix describes the manner in which the compliance monitoring site review activities were conducted, the resulting data were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the health plans.

Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the health plans' compliance with quality assessment and performance improvement (QAPI) program standards.

The assessment of this compliance was accomplished through monitoring tools developed by the Department that incorporated questions from the protocol and items from the current contract. The Department conducted the compliance monitoring evaluation activities, with the results presented by the EQRO in this EQR technical report.

Beginning in 2007, each site review addressed approximately one-third of the 14 contract standards to ensure that over a three-year period, all of the standards were evaluated at least once. The primary objective of the 2006 and 2007 site reviews was to determine health plan compliance with federal and State regulations and with contractual requirements in the following five compliance areas: Audits and Reporting, Claims Processing, Confidentiality, Member Facilitation and Accommodation, and Member Rights and Responsibilities. In 2008, the Department completed a focused site review. The four contract provisions evaluated were: Grievance and Appeal Process, Quality Assurance Program, Credentialing and Recredentialing of Providers, and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

The Department and the individual health plans used the information and findings from the compliance monitoring evaluations to:

- Evaluate the quality and timeliness of, and access to, care furnished by the health plans.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate the current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection

The site review process consisted of a desk audit and an administrative office visit for each health plan. The primary technical method of data collection was the compliance monitoring tool. The Department also followed the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Questions and documents submitted for review were derived from the protocols.

Health plan site reviews consisted of the following:

- **Desk Audit:** The desk audit component included a document request. A list of documents related to each provision was developed and requested from the health plan. The Department staff reviewed each document for evidence of compliance with the applicable provision. Examples of requested documentation included: provider service and delegation agreements and contracts, policies and procedures, practice guidelines, member and provider handbooks, marketing materials, privacy notices, notices of action, release forms, and other easily reviewable documentation. Quality Improvement Section employees conducted the desk audit at the Department's offices in advance of the administrative office visit.
- **Administrative Office Visit:** The Department conducted an on-site review at the health plan's administrative office. The visit consisted of an in-person interview with health plan staff and on-site review of health plan documents and logs not included in the pre-on-site desk audit review. Examples of documents reviewed on-site included appeal files, grievance records, credentialing committee minutes, credentialing files, Clinical Laboratory Improvement Amendments Certificates, and reviews of member medical records. Questions noted from the desk audit were addressed during the on-site interview process. Interviews were targeted to assess the health plan's processes and compliance with its policies and procedures. The administrative office visit component of the site review also included an evaluation of the plan's follow up to prior-year review recommendations.

At the end of the administrative office visit, an exit interview with health plan representative(s) summarized the findings, strengths, and areas for improvement.

Description of Data Obtained

To assess the health plans' compliance with federal and State requirements, the Department obtained information from a wide range of written documents produced by the health plans, including:

- Committee meeting agendas, minutes, and handouts.
- Policies and procedures.
- The QAPI program plan, work plan, and annual evaluation.
- Management/monitoring reports (e.g., grievances, utilization).
- Quarterly compliance reports.
- Provider service and delegation agreements and contracts.
- Clinical review criteria.

- Practice guidelines.
- The provider manual and directory.
- The member handbook and informational materials.
- Staff training materials and documentation of attendance.
- Member satisfaction results.
- Correspondence.
- Records or files related to appeals, grievances, denials, documentation of services, recredentialing, and care coordination.

The Department obtained additional information for the site review through interaction, discussions, and interviews with key health plan staff (e.g., health plan leadership, member services staff, the medical director, etc.).

Data Aggregation, Analysis, and How Conclusions Were Drawn

Upon completion of the site review, the Department aggregated all information obtained. The Department analyzed the findings from the document and record reviews and from the interviews. The findings resulted in scores of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. A summary finding for each contract provision was determined by adding the number of compliant provisions the plan received out of the number of applicable provisions. For records reviewed (e.g., medical records, credentialing files) each record was evaluated based on the total number of the plan's compliant elements out of the applicable elements. A finding for each record review area was determined based on the number of the plan's compliant elements out of the applicable elements.

After completing data aggregation, analysis, and scoring, the Department prepared a preliminary site review report of the findings. The health plans were given the opportunity to respond to the Department's report. Health plan comments were addressed and any necessary corrections were made to the final report. Standards that received a *Partially Met* or *Not Met* rating required a health plan corrective action plan (CAP). The Department reviews and approves the CAPs and related documents and monitors performance until compliance is demonstrated.

The BBA, at 42 CFR 438.204(d) and (g) and at 438.320, provides a framework for using findings from EQR activities to evaluate quality, timeliness, and access. HSAG recognizes the interdependence of quality, timeliness, and access, and assigned each of the standards and record reviews to one or more of the three domains. Using this framework, Table A-1 shows HSAG's assignment of standards and record reviews to the three domains of quality, timeliness, and access.

Table A-1—Assignment of Standards to Performance Domains

Standards	Quality	Timeliness	Access
Grievance and Appeal	✓		
Quality Assurance Program	✓		
Credentialing and Recredentialing	✓		
EPSDT Program	✓	✓	✓

Appendix B. EQR Activities—Validation of Performance Measures

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of performance measure activities was conducted, the resulting data were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the health plans.

Objectives

As set forth in 42 CFR 438.358, validation of performance measures was one of the mandatory EQR activities. All of the performance measures for the Colorado health plans and PCPP were HEDIS measures. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

DHMC and RMHP had existing business relationships with licensed organizations that conducted HEDIS audits for their other lines of business. The Department allowed the health plans to use their existing auditors. The Department mandated that HSAG conduct the NCQA HEDIS Compliance Audit for PCPP. The NCQA HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the health plan's processes than the requirements for validating performance measures as set forth by CMS. Therefore, using this audit methodology complied with both NCQA and CMS specifications and allowed for a complete and reliable evaluation of the health plans. A description of the NCQA audit process follows.

Technical Methods of Data Collection

The following process describes the standard practice for HEDIS audits regardless of the auditing firm. HSAG used a number of different methods and information sources to conduct the audit assessment, including:

- Teleconference calls with Department personnel and vendor representatives, as necessary.
- Detailed review of the Department's completed responses to the Baseline Assessment Tool (BAT)—published by NCQA as Appendix B to the *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*—and updated information communicated by NCQA to the audit team directly.

- On-site meetings at the Department's offices, including:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Reabstraction of a sample of medical records selected by the auditors, with a comparison of results to the Department's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the Department's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates as presented within the NCQA-published Interactive Data Submission System (IDSS)—2008 completed by the Department or its contractor.
- Interviews by auditors, as part of the on-site visit, of a variety of individuals whose job functions or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS coordinator, information systems director, medical records staff, claims processing staff, enrollment and provider data manager, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors or contractors who provided or processed HEDIS 2008 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

The Department was responsible for preparing and providing the performance report for PCPP, and the health plans were responsible for their respective reports. The auditor's responsibility was to express an opinion on the performance report based on the auditor's examination, using procedures NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, HSAG did review the audit reports produced by the other licensed organizations. HSAG did not discover any questionable findings or inaccuracies in the reports; therefore, HSAG agreed that these reports were an accurate representation of the health plans.

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Baseline Assessment Tool (BAT)**. The completed BAT provided background information on the Department's and health plans' policies, processes, and data in preparation for the on-site validation activities.

- **Certified Software Report**. The vendor's certified software report was reviewed to confirm that all of the required measures for reporting had a *Pass* status.
- **Previous Performance Measure Reports**. Previous performance measure reports were reviewed to determine trending patterns and rate reasonability.
- **Supporting Documentation**. This additional information assisted reviewers with completing the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **On-site Interviews and Demonstrations**. This information was obtained through interaction, discussion, and formal interviews with key health plan and State staff members, as well as through system demonstrations.

Table B-1 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table B-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
BAT	CY 2007
Certified Software Report	CY 2007
Performance Measure Reports	CY 2007
Supporting Documentation	CY 2007
On-site Interviews and Demonstrations	CY 2007

Note: CY stands for calendar year.

Data Aggregation, Analysis, and How Conclusions Were Drawn

The following process describes the standard practice for HEDIS audits regardless of the auditing firm.

HSAG determined results for each performance measure based on the validation activities previously described. After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for PCPP. HSAG forwarded his report to the Department and PCPP. Health plan auditors forwarded reports to the Department and the health plans.

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate the domains of quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access, and has assigned each of the performance measures to one or more of the three domains. Using this framework, Table B-2 shows HSAG's assignment of performance measures to these domains.

Table B-2—Assignment of Performance Measures to Performance Domains			
Performance Measures	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status—(Combo #2 and Combo #3)	√	√	
Lead Screening in Children	√		√
Well-Child Visits in the First 15 Months of Life, 6+ Visits	√	√	
Well-Child Visits 3–6 Years of Life	√	√	
Adolescent Well-Care Visits	√	√	
Adults' Access to Preventive/Ambulatory Health Services			√
Timeliness of Prenatal Care	√	√	√
Postpartum Care	√	√	√
Use of Services: Inpatient Utilization—General Hospital Acute Care			√
Use of Services: Ambulatory Care			√
Cholesterol Management for People With CV Conditions (changed in 2007)	√		
Follow-Up Care for Children Prescribed ADHD Medication	√		
Annual Monitoring for Patients on Persistent Medications	√		
RRU for People With Diabetes[A]			
RRU for People With Asthma[A]			
RRU for People With COPD[A]			
[A] Measures related to relative resource use (RRU) cannot be categorized based on the quality-timeliness-access framework.			

Appendix C. EQR Activities—Validation of Performance Improvement Projects

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of performance improvement activities was conducted, the resulting data were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of and access to care furnished by the health plans.

Objectives

As part of its quality assessment and performance improvement program, the Department required each health plan to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time in both clinical care and nonclinical areas. This structured method of assessing and improving health plan processes is expected to have a favorable affect on health outcomes and member satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State was required to validate the PIPs conducted by its contracted health plans and PIHPs. The Department contracted with HSAG to meet this validation requirement.

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

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

For each health plan, HSAG performed validation activities on two PIPs.

Technical Methods of Data Collection

The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and evaluation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

HSAG, with the Department's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the health plan's PIP Summary Form. This form provided detailed information about each health plan's PIP as it related to the 10 activities being reviewed and evaluated.

Table C-1—Description of Health Plan Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (Completed by the Health Plan)	FY 2006–2007

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP review team scored the evaluation elements within each activity as *Met, Partially Met, Not Met,* or *NA*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

All PIPs were assigned a validation status as follows:

- *Met*: All critical elements were *Met* and 80 to 100 percent of all critical and noncritical elements were *Met*.
- *Partially Met*: All critical elements were *Met* and 60 to 79 percent of all critical and noncritical elements were *Met*, or one critical element or more was *Partially Met*.

- *Not Met*: All critical elements were *Met* and less than 60 percent of all critical and noncritical elements were *Met*, or one critical element or more was *Not Met*.
- *Not Applicable (NA)*: HSAG removed elements designated as *NA* (including critical elements if they were not assessed) from all scoring. (For example, an administrative study would not include medical record review. HSAG would give elements related to medical record review an *NA* validation status and not include these *NA* elements in any scores).
- *Not Assessed:* HSAG removed elements designated as *Not Assessed* (including critical elements) from all scoring. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining steps in the CMS protocol.
- *Point of Clarification*: HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would have demonstrated a stronger understanding of CMS protocols.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total number of evaluation elements *Met* by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*. A critical element percentage score was then calculated by dividing the total number of critical elements *Met* by the sum of the critical elements *Met, Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- *Met*: Confidence/high confidence in the reported PIP results
- *Partially Met*: Low confidence in the reported PIP results
- *Not Met*: Reported PIP results that were not credible

After completing the validation review, HSAG prepared a report of the findings and recommendations for each validated PIP. HSAG forwarded these reports, which complied with 42 CFR 438.364, to the Department and the appropriate health plan.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain.

Appendix D. EQR Activities—Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Introduction

This appendix describes the manner in which the CAHPS data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the health plans.

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

Technical Methods

The technical method of data collection was through the administration of the CAHPS 4.0H Adult Medicaid Survey for the adult population and the CAHPS 3.0H Child Medicaid Survey (without the children with chronic conditions measurement set) for the child population. The surveys include a set of standardized items (51 items for the CAHPS 4.0H Adult Medicaid Survey and 76 items for the CAHPS 3.0H Child Medicaid Survey) that assess patient perspectives on care. The surveys were administered in both English and Spanish. Clients identified as Spanish-speaking were administered the Spanish instrument. All other clients received an English version of the survey. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed for the selection of members and the distribution of surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was "Not Applicable" (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the

sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite questions in the adult Medicaid survey response choices fell into one of the following two categories: 1) "Never," "Sometimes," "Usually," and "Always" or 2) "Definitely No," "Somewhat No," "Somewhat Yes," and "Definitely Yes." For the child Medicaid survey, response choices fell into one of two categories: 1) "Never," "Sometimes," "Usually," and "Always" or 2) "Big Problem," "Small Problem," and "Not a Problem."

A positive or top-box response for the composites was defined as a response of "Always," "Not a Problem," or "Definitely Yes." The percentage of top-box responses was referred to as a global proportion for the composite scores.

Description of Data Obtained

Table D-1 and Table D-2 present the question summary rates (i.e., the percentage of respondents offering a positive response) for the 2008 global ratings for the adult and child populations. The plans provided to HSAG the data presented in the following tables for DHMC and RMHP. The plans reported that NCQA methodology was followed in calculating these results. HSAG did not validate these results. Measures at or above the NCQA national averages are highlighted in yellow.

Table D-1—NCQA National Averages and Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Adult Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	60.5%	71.6%	68.4%	60.9%
Rating of Specialist Seen Most Often	59.7%	60.0%	68.4%	62.0%
Rating of All Health Care	46.6%	52.2%	54.8%	46.1%
Rating of Health Plan	52.8%	56.4%	63.5%	48.2%

A question summary rate is the percentage of respondents offering a positive response (a value of 9 or 10).

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Table D-2—NCQA National Averages and Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Child Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	64.6%	†	†	66.7%
Rating of Specialist Seen Most Often	61.9%	†	†	65.2%
Rating of All Health Care	64.0%	†	†	67.8%
Rating of Health Plan	63.6%	†	†	63.0%

A question summary rate is the percentage of respondents offering a positive response (values of 9 or 10).

A minimum of 100 responses is required for a global rating to be reported as a CAHPS survey result. Global ratings that do not meet the minimum number of responses are denoted as Not Applicable (NA).

† FY 2007–2008 child Medicaid data are not reportable for DHMC and RMHP, as specified by the Department.

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Table D-3 and Table D-4 present the global proportions (i.e., the percentage of respondents offering a positive response) for the 2008 composite scores for the adult and child populations. The plans provided to HSAG the data presented in the following tables for DHMC and RMHP. The plans reported that NCQA methodology was followed in calculating these results. HSAG did not validate these results.

Table D-3—NCQA National Averages and Global Proportions for Composite Scores

Measure of Member Satisfaction	Adult Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	47.3%	44.9%	61.3%	49.9%
Getting Care Quickly	54.0%	48.1%	63.4%	55.8%
How Well Doctors Communicate	66.8%	73.8%	69.7%	62.5%
Customer Service	*	NA	66.3%	NA
Shared Decision Making	58.4%	59.0%	59.3%	61.1%

A global proportion is the percentage of respondents offering a positive response ("Always" or "Definitely Yes").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

* Due to changes in the Customer Service composite, 2007 NCQA CAHPS national averages were not calculated for this measure.

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Table D-4—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	**Child Medicaid 2008**			
	2007 NCQA CAHPS National Averages	**DHMC**	**RMHP**	**PCPP**
Getting Needed Care	80.3%	†	†	78.0%
Getting Care Quickly	50.9%	†	†	56.4%
How Well Doctors Communicate	66.3%	†	†	68.4%
Courteous and Helpful Office Staff	67.9%	†	†	70.7%
Customer Service	73.6%	†	†	NA

A global proportion is the percentage of respondents offering a positive response ("Always" or "Not a Problem").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

† FY 2007–2008 child Medicaid data are not reportable for DHMC and RMHP, as specified by the Department.

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Overall perceptions of the quality of medical care and services received can be assessed both from criterion and normative frames of reference. A normative frame of reference was used to compare the responses within each health plan.

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access, and has assigned each of the CAHPS survey measures to one or more of the three domains. Using this framework, Table D-5 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table D-5—Assignment of CAHPS Measures to Performance Domains

CAHPS Measures	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Courteous and Helpful Office Staff	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Introduction

HSAG conducted two focused studies of health care for the Department. The Adolescent Well-Care focused study was a remeasurement of the study conducted in FY 2005–2006. The second study, Coordination of Care Phase I: Utilization of Services for Members Diagnosed With a Serious Mental Illness Focused Study, was conducted to provide baseline medical services utilization information to members diagnosed with an SMI.

Objectives

The objectives of each of the focused studies were specific to the clinical topic. The objectives are separately delineated under a subheading for the clinical topic.

Coordination of Care Focused Study

The goal of this study was to provide baseline information on utilization of medical services for members diagnosed with an SMI. This focused study addressed the following question: When members with an SMI access medical care, where and how frequently do they access this care and what are the three most common diagnoses?

With this information, the Department and health plans will be better informed and positioned to develop effective interventions to improve coordination with the behavioral health professionals treating this population.

Adolescent Well-Care Focused Study

The goal of the FY 2007–2008 focused study was to determine the impact of health plan interventions on the rate of adolescent well-care visits. The study addressed the following question: To what extent are Colorado Medicaid providers performing adolescent well-care visits?

Comparing the results of the FY 2007–2008 study with the results of the FY 2005–2006 study will help the Department and the health plans measure the success of any intervention plans that may have been implemented since the last study. The results of the study will help the Department and health plans be better informed and positioned to develop effective interventions to improve the rate of adolescent well-care visits.

Technical Methods of Data Collection

The technical methods of data collection and analysis for each of the two focused studies were specific to the clinical topic of each study. These methodologies are separately delineated under a subheading for the clinical topic.

Coordination of Care Focused Study

The study was performed using administrative claims data for the entire eligible population; sampling was not performed. The eligible population included all Medicaid members identified by the Department with a qualifying SMI diagnosis who were 21 years of age or older as of July 1, 2006. Members had to be continuously enrolled in the same Colorado Medicaid health plan (PCPP, DHMC, or RMHP) from July 1, 2006, through June 30, 2007, with one or more gaps in enrollment totaling no more than 60 days.

Using the supplied eligible population for PCPP, HSAG obtained member utilization rates for all measures (except mental health inpatient admissions, which were provided by the Department) using a programmed data pull from claims/encounter records. RMHP and DHMC determined member utilization rates for their eligible population, then submitted to HSAG a summary data file containing the numerators and denominators for all measures except mental health inpatient admissions. HSAG used the numerators and denominators provided by RMHP, DHMC, and the Department to calculate aggregated medical utilization rates for all measures.

Adolescent Well-Care Focused Study

The eligible population consisted of all Colorado Medicaid members 12 to 21 years of age as of December 31, 2007. An eligible member was continuously enrolled in one of the following health plans from January 1, 2007, through December 31, 2007, with no more than one 30-day gap in enrollment: PCPP, DHMC, or RMHP. HSAG used administrative data to identify Colorado Medicaid PCPP members. Data collection was accomplished using a programmed pull from claims/encounter files of eligible members. RMHP and DHMC were responsible for identifying their eligible populations and submitting a data submission file to HSAG containing the numerators and denominators for the five measures being studied. HSAG calculated rates for PCPP as well as an aggregated rate for all health plans combined.

Description of Data Obtained

The description of the data obtained in each of the focused studies was specific to the clinical topic of each study. These descriptions are separately delineated under a subheading for the clinical topic.

Coordination of Care Focused Study

The FY 2007–2008 coordination of care Phase 1 focused study included the following measures:

Measure #1: ***Members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider***

- A primary care type of provider was defined as follows: family practice, general practice, internal medicine, obstetrics/gynecology, gerontology, nurse practitioner, physician assistant, or pediatrics.

Measure #2: ***Members with an SMI diagnosis who had at least one emergency room visit during the measurement period***

Measure #3a: ***Members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period***

Measure #3b: ***Members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period***

Measure #4: ***Utilization of services by members with an SMI diagnosis during the measurement period***

- Service utilization was defined as follows: number of visits, average visits per member, and the top three diagnoses for members by preventive/ambulatory care visits, emergency room visits, and physical and mental health inpatient admissions (only the member's first admission in the review period and its associated primary diagnosis was tracked for mental health inpatient admissions).

Adolescent Well-Care Focused Study

The FY 2007–2008 Colorado Adolescent Well-Care Focused Study included five measures:

Measure 1: *Adolescent well-care visits* (HEDIS 2008 methodology)

- The number of adolescents who had at least one well-care visit with a primary care provider or obstetrician/gynecologist during the measurement year. (This measure was based on the HEDIS 2008 technical specifications.)

Measure 2: *Adolescents with no services*

- The number of adolescents who had no services, (i.e., no claims/encounter data) including well-care visits, during the measurement year.

Measure 3: *Adolescents with a physician office visit, but no well-care visit*

- The number of adolescents who had no well-care visits (as defined in Measure 1), but had at least one physician office visit in an ambulatory setting (e.g., a physician office, hospital emergency department, or urgent care center) during the measurement year.

Measure 4: *Adolescents with services, but neither physician office visits nor well-care visits*

- The number of adolescents who had no well-care visits (as defined in Measure 1) or physician office visits in an ambulatory setting (as defined in Measure 3), but had services (e.g., lab, inpatient, or pharmacy) in other settings during the measurement year.

Measure 5: *Potential and missed opportunity*

- The number of adolescents who did not have any well-care visits (as defined in Measure 1) during the measurement year, but had at least one other type of service. This measure is the summation of the numerators from Measures 2, 3, and 4.

Data Aggregation, Analysis, and How Conclusions Were Drawn

All measures evaluated in both focused studies were based on administrative date and used the entire eligible population. No sampling was employed.

The method of data analysis for both studies used measure rates for each of the health plans. The rates were formed by dividing the number of people who had received the selected services by the number of the people who were eligible for those services. The average visits per member were calculated by dividing the total number of visits by the eligible SMI population. The measures were then assessed both through comparative and normative frames of reference.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the health plans from the focused study findings, HSAG assigned each of the measures to one or more of the three domains as depicted in Table E-1.

Table E-1—Assignment of Focused Study Measures to Performance Domains

Focused Studies Indicators	Quality	Timeliness	Access
Coordination of Care			
Members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider			✓
Members with an SMI diagnosis who had at least one emergency room visit during the measurement period			✓
Members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period			✓
Members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period			✓
Utilization of services by members with an SMI diagnosis during the measurement period			✓
Adolescent Well-Care			
Adolescent well-care visits (HEDIS)			✓
Adolescents with no services			✓
Adolescents with a physician office visit but no well-care visit			✓
Adolescents with services but no physician office visit or well-care visit			✓
Potential and missed opportunity			✓

Appendix F. Summary Tables of EQR Activity Results—All Health Plans

Introduction

The following details findings for each health plan from the five EQR activities conducted. This section also compares health plan findings and the statewide average.

Results From the Compliance Monitoring Site Reviews

Table F-1––Summary of Scores for the Standards for FY 2007–2008

Description of Standard	DHMC	RMHP	Statewide Average*
Grievance and Appeal	92%	96%	94%
Quality Assurance Program	96%	100%	98%
Credentialing and Recredentialing	100%	98%	99%
EPSDT Program	100%	100%	100%
Totals	**98%**	**98%**	**98%**

* Statewide average rates are weighted averages formed by summing the individual numerators and dividing by the sum of the individual denominators.

Results From the Validation of Performance Measures

Changes were made to specifications for the following measures: *Childhood Immunization Status (Combo #2* and *#3)*, *Timeliness of Prenatal Care*, and *Postpartum Care*. The changes likely resulted in changes in rates not directly comparable to previous years' rates or national benchmarks. Consequently, the rates for these measures are displayed for information purposes only.

For FY 2006–2007, data are not presented for *Adults' Access to Preventive/Ambulatory Health Services*, *Use of Services: Inpatient Utilization—General Hospital Acute Care*, *Use of Services: Ambulatory Care*, and *Cholesterol Management for People With CV Conditions* (changed in 2007) because data were not required by the Department for the 2006–2007 External Quality Review Technical Report.

Table F-2––Comparison Trends of Quality Performance by Colorado Medicaid Health Plans and PCPP						
Performance Measures	DHMC		RMHP		PCPP	
	2007	2008	2007	2008	2007	2008
Childhood Immunization Status—Combo #2	84.78%	85.16%	74.46%	81.50%	49.39%	78.60%
Childhood Immunization Status—Combo #3	83.70%	84.18%	68.01%	75.86%	41.72%	69.82%
Well-Child Visits in the First 15 Months of Life, 6+ Visits	61.11%	63.11%	27.66%	30.60%	35.53%	56.48%
Well-Child Visits 3–6 Years of Life	68.61%	56.93%	67.09%	59.55%	21.12%	42.58%
Adolescent Well-Care Visits	35.28%	31.85%	39.48%	40.84%	27.49%	15.16%
Adults' Access to Preventive/Ambulatory Health Services						
20–44 Years	—	66.11%	—	83.71%	—	64.59%
45–64 Years	—	68.69%	—	87.99%	—	63.67%
65+ Years	—	56.36%	—	94.98%	—	15.15%
Timeliness of Prenatal Care	77.39%	82.73%	97.08%	97.12%	54.01%	63.45%
Postpartum Care	33.91%	55.23%	75.91%	72.84%	50.61%	65.27%
Use of Services: Inpatient Utilization—General Hospital Acute Care						
Discharges (Per 1,000 Member Months)	—	9.74	—	14.8	—	8.29
Days (Per 1,000 Member Months)	—	39.66	—	48.45	—	40.94
Average Length of Stay	—	4.07	—	3.27	—	4.94
Use of Services: Ambulatory Care (Per 1000 Member Months)						
Outpatient Visits	—	246.58	—	440.63	—	298.67
ED Visits	—	36.29	—	54.09	—	50.18
Ambulatory Surgery/Procedures	—	3.44	—	12.17	—	7.14
Observation Room Stays Resulting in Discharge	—	1.60	—	1.17	—	1.43
Cholesterol Management for People With CV Conditions (changed in 2007)						
LDL-C Screening Performed	—	70.59%	—	74.39%	—	69.23%
LDL-C Control (< 100 mg/dL)	—	50.98%	—	57.32%	—	24.48%
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	—	16.22%	—	NB	—	33.86%
Continuation and Maintenance (C&M) Phase	—	NA	—	NB	—	31.25%
Annual Monitoring for Patients on Persistent Medications	—	77.28%	—	65.20%	—	79.96%

— is shown when no data were available or the measure was not reported in last year's technical report.
NA is shown when there were fewer than 30 cases in the denominator for the rate.
NB is shown when the required benefit was not offered for the report measure.

Results From the Validation of Performance Improvement Projects

Table F-3––Summary of Data From Validation of Performance Improvement Projects						
Validation Activity		Total Possible Evaluation Elements	DHMC		RMHP	
			Childhood Immunization	Pharmacy Access	Postpartum Visits	Well-Care Visits
I.	Appropriate Study Topic	6	6/6	6/6	6/6	6/6
II.	Clearly Defined, Answerable Study Question	2	2/2	2/2	2/2	2/2
III.	Clearly Defined Study Indicator(s)	7	6/6	6/6	6/6	6/6
IV.	Use a Representative and Generalizable Study Population	3	3/3	3/3	3/3	3/3
V.	Valid Sampling Techniques	6	NA	6/6	6/6	NA
VI.	Accurate/Complete Data Collection	11	11/11	6/6	11/11	6/6
VII.	Appropriate Improvement Strategies	4	3/3	2/2	3/3	2/2
VIII.	Sufficient Data Analysis and Interpretation	9	8/8	9/9	9/9	4/4
IX.	Real Improvement Achieved	4	1/4	2/4	1/4	NA
X.	Sustained Improvement Achieved	1	NA	NA	1/1	NA
Total		**53**	**40/43**	**42/44**	**48/51**	**29/29**

Notes:
1. Not all possible evaluation elements were scored. Some elements were Not Assessed (NA) (e.g., Activity V, Sampling, was NA when the entire population was used). Other elements were NA because the PIP had not yet reached that stage of the study.
2. Only scored elements were used when validating the PIP.
3. Total scores are presented as "number met/number scored."

Results From the Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table F-4—NCQA National Averages and Question Summary Rates for Global Ratings				
Measure of Member Satisfaction	Adult Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	60.5%	71.6%	68.4%	60.9%
Rating of Specialist Seen Most Often	59.7%	60.0%	68.4%	62.0%
Rating of All Health Care	46.6%	52.2%	54.8%	46.1%
Rating of Health Plan	52.8%	56.4%	63.5%	48.2%
A question summary rate is the percentage of respondents offering a positive response (a value of 9 or 10).				
Indicates a rate that is at or above the 2007 NCQA CAHPS national average.				

Table F-5—NCQA National Averages and Question Summary Rates for Global Ratings				
Measure of Member Satisfaction	Child Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	64.6%	†	†	66.7%
Rating of Specialist Seen Most Often	61.9%	†	†	65.2%
Rating of All Health Care	64.0%	†	†	67.8%
Rating of Health Plan	63.6%	†	†	63.0%
A question summary rate is the percentage of respondents offering a positive response (values of 9 or 10).				
A minimum of 100 responses is required for a global rating to be reported as a CAHPS survey result. Global ratings that do not meet the minimum number of responses are denoted as Not Applicable (NA).				
† FY 2007–2008 child Medicaid data are not reportable for DHMC and RMHP, as specified by the Department.				
Indicates a rate that is at or above the 2007 NCQA CAHPS national average.				

Table F-6—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	Adult Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	47.3%	44.9%	61.3%	49.9%
Getting Care Quickly	54.0%	48.1%	63.4%	55.8%
How Well Doctors Communicate	66.8%	73.8%	69.7%	62.5%
Customer Service	*	NA	66.3%	NA
Shared Decision Making	58.4%	59.0%	59.3%	61.1%

A global proportion is the percentage of respondents offering a positive response ("Always" or "Definitely Yes").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

* Due to changes in the *Customer Service* composite, 2007 NCQA CAHPS national averages were not calculated for this measure.

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Table F-7—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	Child Medicaid 2008			
	2007 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	80.3%	†	†	78.0%
Getting Care Quickly	50.9%	†	†	56.4%
How Well Doctors Communicate	66.3%	†	†	68.4%
Courteous and Helpful Office Staff	67.9%	†	†	70.7%
Customer Service	73.6%	†	†	NA

A global proportion is the percentage of respondents offering a positive response ("Always" or "Not a Problem").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

† FY 2007–2008 child Medicaid data are not reportable for DHMC and RMHP, as specified by the Department.

Indicates a rate that is at or above the 2007 NCQA CAHPS national average.

Results From the Focused Studies

Table F-8—Focused Study Rates *for* DHMC		
Focused Study Indicators	**FY 2006–2007 Rate**	**FY 2007–2008 Rate**
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	71.2%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	19.2%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	6.1%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	8.4%
Adolescent Well–Care		
Adolescent well-care visits (HEDIS)	27.8%	31.9%
*Adolescents with no services***	27.3%	22.3%
Adolescents with a physician office visit but no well-care visit	40.2%	36.6%
*Adolescents with services but no physician office visit or well–care visit***	4.7%	9.2%
Potential and missed opportunity	72.2%	68.1%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

** A lower percentage indicates better performance.

Table F-9 Focused Study Rates *for* RMHP		
Focused Study Indicators	**FY 2006–2007 Rate**	**FY 2007–2008 Rate**
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	88.3%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	45.6%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	17.4%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	2.0%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	35.7%	40.8%
*Adolescents with no services***	8.9%	0.6%
Adolescents with a physician office visit but no well-care visit	51.2%	56.6%
*Adolescents with services but no physician office visit or well-care visit***	4.2%	2.0%
Potential and missed opportunity	87.6%	85.1%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.
** A lower percentage indicates better performance.

Table F-10—Focused Study Rates *for* PCPP		
Focused Study Indicators	**FY 2006–2007 Rate**	**FY 2007–2008 Rate**
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	60.2%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	27.3%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	11.0%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	3.3%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	12.4%	14.9%
*Adolescents with no services***	7.5%	5.3%
Adolescents with a physician office visit but no well-care visit	56.7%	58.8%
*Adolescents with services but no physician office visit or well-care visit***	23.4%	21.0%
Potential and missed opportunity	87.6%	85.1%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.
** A lower percentage indicates better performance.

Table F-11—Focused Study Rates *for* Statewide Average Rates		
Focused Study Indicators	**FY 2006–2007 Rate**	**FY 2007–2008 Rate**
Coordination of Care		
Percentage of members with an SMI diagnosis who had at least one preventive/ambulatory visit in an outpatient setting during the measurement period with a primary care type of provider	*	68.4%
Percentage of members with an SMI diagnosis who had at least one emergency room visit during the measurement period	*	27.1%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a physical health hospital during the measurement period	*	10.2%
Percentage of members with an SMI diagnosis who had at least one inpatient admission in a mental health hospital during the measurement period	*	4.9%
Adolescent Well-Care		
Adolescent well-care visits (HEDIS)	22.4%	25.3%
*Adolescents with no services***	11.7%	10.8%
Adolescents with a physician office visit but no well-care visit	49.3%	50.3%
*Adolescents with services but no physician office visit or well-care visit***	16.7%	13.6%
Potential and missed opportunity	77.6%	74.7%

* Because the FY 2007–2008 coordination of care study is a baseline study, there are no comparable rates.

** A lower percentage indicates better performance.